Ombudsman
ONTARIO

ONTARIO'S WATCHDOG

2012-2013

Annual Report

July 16, 2013

The Honourable Dave Levac
Speaker
Legislative Assembly
Province of Ontario
Queen's Park

Dear Mr. Speaker,

I am pleased to submit my Annual Report for the period of April 1, 2012 to March 31, 2013, pursuant to section 11 of the *Ombudsman Act*, so that you may table it before the Legislative Assembly.

Yours truly,

André Marin
Ombudsman

Bell Trinity Square
483 Bay Street, 10th Floor, South Tower
Toronto, Ontario
M5G 2C9

Telephone: 416-586-3300
Complaints Line: 1-800-263-1830
Fax: 416-586-3485
TTY: 1-866-411-4211

Website: www.ombudsman.on.ca
Facebook: Ontario Ombudsman
Twitter: @Ont_Ombudsman

Table of Contents

Ombudsman's Message 5

The Multipurpose Ombudsman **5**
- The Barometer 6
- The Horsefly 6
- The Oil Can 6
- The Safety Valve 7
- Our Indoor Voice 7
- Special Weapons and Tactics 7
- Unfinished Business 9
- No Rush for MUSH 10
  - Anybody but the Ombudsman 10
  - Hospital horrors 12
  - Long-term care lapses 12
  - Ornge air ambulances – flying out of reach 13
  - Give us a "C" – children's aid societies 14
  - OMLET still cooking 15
- Closing Thoughts 16

The Year in Review 17

Beyond Scrutiny: The push for MUSH **17**
- "M" – Municipalities 18
- "U" – Universities 18
- "S" – School Boards 19
- "H" – Hospitals 19
- Long-Term Care Homes 21
- Children's Aid Societies 21
- Police 22

Operations Overview **23**
- Complaint Trends and Significant Cases in 2012-2013 24
  - Ministry of the Attorney General 24
  - Ministry of Community Safety and Correctional Services 24
  - Ministry of Community and Social Services 26
  - Ministry of Children and Youth Services 28
  - Ministry of Energy 29
  - Ministry of Health and Long-Term Care 30
  - Ministry of Government Services / Ministry of Health and Long-Term Care 31
  - Ministry of Natural Resources 32
  - Ministry of Training, Colleges and Universities 32
  - Ministry of Transportation 33

Training and Consultation **35**

Communications and Outreach **39**

Special Ombudsman Response Team **44**
SORT investigations completed in 2012-2013 44
The Code – Ministry of Community Safety and Correctional Services 44
In the Line of Duty – Ontario Provincial Police and Ministry of Community Safety and Correctional Services 46
Dental implants – Ministry of Health and Long-Term Care 48
Ongoing SORT investigations 49
Adults with developmental disabilities in crisis – Ministry of Community and Social Services 49
Monitoring of drivers with uncontrolled hypoglycemia – Ministry of Transportation 50
Completed SORT assessments in 2012-2013 50
Slots at Racetracks program – Ontario Lottery and Gaming Corporation 50
Updates on previous SORT investigations 51
Non-emergency medical transportation services – Ministry of Health and Long-Term Care, Ministry of Transportation 51
Caught in the Act – Expansion of police powers for Toronto G20 summit – Ministry of Community Safety and Correctional Services 52
Monitoring of long-term care homes – Ministry of Health and Long-Term Care 52
Oversight Undermined and *Oversight Unseen* – Ministry of the Attorney General and Special Investigations Unit 53
Between a Rock and a Hard Place – Care and custody of children with severe special needs – Ministry of Children and Youth Services 55

Case Summaries **56**
Ministry of the Attorney General 56
Ministry of Community and Social Services 59
Ministry of Energy 66
Ministry of Finance 66
Ministry of Government Services 68
Ministry of Health and Long-Term Care 69
Ministry of Labour 71
Ministry of Natural Resources 72
Ministry of Training, Colleges and Universities 72
Ministry of Transportation 73

Your Feedback **74**

Appendix 1 – Complaint Statistics **78**

Appendix 2 – How We Work **86**

Appendix 3 – About the Office **87**

Appendix 4 – Financial Report **88**

Ombudsman's Message

The Multipurpose Ombudsman

The stories in this report, arising from the **19,726** cases we received in 2012-2013, demonstrate how my Office uses a variety of tools to resolve individual and systemic concerns. Picture a "Swiss Army"-style knife with all sorts of useful accountability gadgets: A barometer, a horsefly, an oil can, a safety valve and more. Like a barometer, my Office alerts citizens, legislators, and government organizations to trending complaints before problems escalate into crises. Like a horsefly, we nip at bureaucratic heels and nudge officials to change direction. Like an oil can, we reduce friction, facilitate resolution and smooth over bureaucratic tangles. And like a safety valve, we act as a last resort to protect citizens' rights, health and welfare – and forestall systemic disaster.

The Barometer

In **2012-2013**, we continued to work proactively with government organizations – particularly those that generate a large volume of complaints – to address systemic issues. A case in point is the **Family Responsibility Office** (**FRO**), which once again topped the list as the most complained-about Ontario agency. We met regularly with FRO officials to discuss persistent problems such as a lack of aggressive enforcement, poor record keeping and administrative errors. Our efforts were inspired by people like one woman who was owed nearly **$35,000** in child support that the FRO unwittingly held in a generic account, and another who finally received more than **$12,000** after we persuaded the FRO to step up its enforcement efforts. These and similar cases can be found in the **Case Summaries** section of this report.

We also kept close watch on the Ministry of Transportation's progress in tackling the "ghost licence" issue that we revealed last year. A single complaint from a man convicted of drunk driving led to the discovery that the Ministry had generated more than **1,000,000** dummy licence records since 1966 – whenever it could not match notices of driving offences, collisions or medical suspensions with existing Ontario driver licences. We alerted the Ministry to the risk that some of what it calls "master" licences could be duplicates, meaning some individuals who were supposed to be under suspension might still be on the roads with valid licences. Our red flag prompted the Ministry to review and reconcile its records to better protect public safety. More on this case and others can be found in the **Operations Overview** section of this report.

The Horsefly

Many complaints that we receive require the "horsefly" approach - direct and focused prodding to wake officials up and get them to move in the right direction. This technique is often successfully applied to stand up for the "little guy" – those too vulnerable and without the means to make themselves heard.

For instance, we uncovered a computer glitch that shortchanged a man thousands of dollars in Ontario Disability Support Program benefits. We also convinced the Office of the Public Guardian and Trustee to do the right thing after it wrongly charged legal fees to a client for talking to our Office about his complaint.

The horsefly technique is well suited to cases of **rulitis** – slavish bureaucratic devotion to the rules, to the exclusion of good judgment. We used it in a particularly acute case this year, where the Office of the Registrar General was refusing to issue a birth certificate for a man's baby daughter without an application from the mother, who had died shortly after childbirth.

The Oil Can

By contrast, many cases are resolved through a smoother approach, where bureaucratic machinery is lubricated by an injection of compassion, common sense and creative solutions.

We continued to help many families of adults with developmental disabilities, by facilitating communication between them, the Ministry of Community and Social Services, the Ministry of Children and Youth Services and the host of agencies involved in their services and care. Our case-by-case efforts paid off with enhanced protocols and practices to help children with severe disabilities transition from the child benefit system to services for adults, even as we launched a broader systemic investigation on this issue.

Our oil can was also applied to convince Hydro One to address unfair overbillings and to help students with disability grants through the Ministry of Training, Colleges and Universities.

The Safety Valve

In cases where life, health and welfare are at stake, my Office is often the last resort for desperate citizens. This year, we helped a 72-year-old man with a rare form of cancer get money for specialized out-of-country treatment after his request was denied, even though the Ministry of Health and Long-Term Care had paid for similar therapy for others. Our efforts also sparked the Ministry to improve its processes to ensure proper tracking of these cases in future.

In another case, although Ontario Health Insurance Plan coverage was provided for genetic testing in the U.S. to benefit siblings of a 14-year-old boy who had died suddenly, the Ministry of Health and Long-Term Care denied coverage for families in similar circumstances while it pondered its funding policy. Through escalating discussions up the chain of command at the Ministry, we were able to coax it to change its practice and review such requests on a case-by-case basis.

Our Indoor Voice

While my Office is best known for its "outside" voice – that is, our reports on systemic investigations by our Special Ombudsman Response Team – a great deal of our work is accomplished through a subtle and collaborative approach. We help thousands of Ontarians with straightforward, sensitive or complex issues through confidential, informal dispute resolution.

For instance, since 2009, we have had discussions with the Ministry of Health and Long-Term Care about developing a program for people who need dental implants for medical reasons, often as a result of severe conditions such as cancer. The Ministry had always considered all dental implants to be cosmetic and thus ineligible for Ontario Health Insurance Plan coverage. But this past April, it launched its new Oral and Maxillofacial Reconstruction Program to fund certain prostheses to restore oral function for patients who have no treatment alternatives. This quiet victory for vulnerable people represents the culmination of three years of behind-the-scenes talks, informal investigation and exertion of moral suasion.

In a similar fashion, we encouraged the Ministry of Community Safety and Correctional Services to address delays and inefficiencies in its private security licence application and complaint processes, and we prompted the Death Investigation Oversight Council to improve its communication strategies and use clear, evidence-based reasons in its decisions.

Special Weapons and Tactics

There are cases, however, where shuttle diplomacy and alternative dispute resolution will simply not get the job done. These are the cases where our Special Ombudsman Response Team, or SORT – our systemic field investigation unit – excels.

Our latest ongoing SORT investigation – into how the Ministry of Community and Social Services responds to an apparent lack of services for adults with developmental disabilities who are in crisis – had drawn well over 800 complaints as of the writing of this report. These cases, which we first identified as a trend in 2011-2012, include many heart-rending stories of families with nowhere to turn and young adults with severe special needs ending up in shelters, hospitals and even jail.

SORT also tackled difficult and thorny issues in the two major investigations that resulted in reports in 2012-2013 – operational stress injuries among police, and the use of excessive force against inmates in correctional facilities.

Ombudsman André Marin is greeted by former OPP Detective-Inspector Bruce Kruger (right) after the release of the Ombudsman's report, *In the Line of Duty*, October 24, 2012.

My report ***In the Line of Duty***, issued in October 2012, revealed serious gaps in how the Ontario Provincial Police and the Ministry of Community Safety and Correctional Services address operational stress injuries among police, including depression, addictions, anxiety and post-traumatic stress disorder. The SORT investigation uncovered a persistent stigma against affected officers and a lack of support services for them and their families. The OPP and the Ministry have taken my recommendations seriously, and SORT will monitor their progress as they work towards substantive reform.

> "Please convey to the complete investigative team who participated in this inquiry how gratifying their work has been to the policing community. Generations of police officers will have their lives greatly enriched because of their efforts… I know that through your efforts, lives will be saved."
>
> Retired OPP Detective-Inspector Bruce Kruger, whose complaint sparked the *In the Line of Duty* investigation

Last month, I released ***The Code***, my report on SORT's investigation into how the Ministry of Community Safety and Correctional Services responds to allegations of excessive use of force. This investigation arose from a disturbing trend we identified in 2010 involving cases where correctional staff assaulted inmates and covered up the incidents. We discovered an entrenched "code of silence" amongst some correctional officers who helped colleagues hide brazen acts of assault against vulnerable inmates. The Ministry has undertaken to implement my recommendations, and I will monitor its progress closely.

Unfinished Business

Political events in the past year – including the prorogation of the Legislative Assembly after Premier Dalton McGuinty resigned his post – have unfortunately delayed implementation of reforms arising from some of our earlier investigations. For example, in June 2011, the ministers of Transportation and Health and Long-Term Care jointly announced they would introduce legislation to address non-emergency medical transportation services. This was in response to my investigation into serious concerns about the lack of regulation of these private companies, which are responsible for transporting hundreds of thousands of non-critical patients each year. With the issue apparently resolved, I opted not to release a report on the investigation at that time. But after an election, a prorogation and the elevation of one of the ministers to the Premier's chair, there has been little progress. We continue to receive updates from the ministries to ensure this initiative moves forward.

Similarly, in the wake of my December 2010 report ***Caught in the Act***, concerning the exceptional police powers exercised during the Toronto G20 summit in June 2010, the government moved to replace the outdated *Public Works Protection Act*. It introduced Bill 34, the *Security for Courts, Electricity Generating Facilities and Nuclear Facilities Act,* in February 2012, but it died on the order paper when the Legislature was prorogued. It was reintroduced as Bill 51 on April 2013 and has yet to pass, more than three years after that infamous June weekend. I am hopeful the bill will be implemented soon, to better safeguard civil rights in the province.

Regrettably, the Ministry of the Attorney General has still not moved forward on my recommendations for new legislation to strengthen the Special Investigations Unit (SIU), the independent body responsible for investigating when police are involved in incidents of serious injury or death. My reports ***Oversight Unseen*** (2008) and ***Oversight Undermined*** (2011) extensively detailed the shortcomings of the present system. As well, the Law Society of Upper Canada has discouraged lawyers from jointly representing police witnesses in SIU cases, and the Supreme Court of Canada is considering the issue of lawyers vetting police notes before they are submitted to the SIU. Meanwhile, a lack of police co-operation persists in many SIU investigations, frustrating the public interest. I will continue to observe developments in this area, and consider whether a third investigation and report may be necessary to incite the Ministry into action.

Ombudsman André Marin addresses the 10th World Conference of the International Ombudsman Institute in Wellington, New Zealand, discussing his report *Caught in the Act*, November 8, 2012.

NDP MPP France Gélinas (Nickel Belt) speaks to Ombudsman André Marin at a "Meet the Ombudsman" event at Queen's Park, May 1, 2012.

No Rush for MUSH

Public debate continued to rage this year over whether my Office's mandate should be extended to the MUSH sector – **m**unicipalities, **u**niversities, **s**chool boards and **h**ospitals and long-term care homes, as well as children's aid societies, police and other organizations collectively receiving tens of billions of dollars annually in public funds.

We were forced to turn away **2,541** cases relating to these organizations in 2012-2013, many of them raising serious issues involving the health and welfare of Ontario's most vulnerable citizens – the sick, the elderly, children and youth. No other ombudsman in Canada has such a limited mandate.

I am not the first Ontario Ombudsman to recommend elimination of the arbitrary historical exceptions shielding the **MUSH** sector from my Office's scrutiny. The effort began with the first Ombudsman, Arthur Maloney, who observed in his 1979 *Blueprint for the Office of the Ombudsman of Ontario*:

> "...it is my considered view that the Ombudsman's jurisdiction should similarly be extended to include such organizations as hospitals, universities, boards of education, nursing homes and other such bodies financed in whole or in substantial part with public funds."

Popular grassroots opinion appears solidly behind extending Ombudsman jurisdiction into the MUSH sector. Many MPPs have also shown strong support for this change. The Standing Committee on Government Agencies is poised to consider Bill 42, the *Ombudsman Amendment Act (Children's Aid Societies), 2013*, introduced by NDP MPP Monique Taylor, which would bring children's aid societies within this Office's jurisdiction. And since 2005, more than **100** petitions and **14** private member's bills have supported modernization of my Office's mandate to include the MUSH sector.

Anybody but the Ombudsman

Last June, I was extremely encouraged by the comments of then Premier McGuinty, who initiated discussions with my Office about opening the MUSH sector up to Ombudsman oversight, and told me, **"It is not a matter of if, but when"** this new jurisdiction would be granted. However, less than a year later, his successor Premier Kathleen Wynne rejected the overture made by the leader of the New Democratic Party to extend my Office's authority over hospitals and long-term care homes. The result was an accountability compromise –

no independent external oversight in this area, but the promise of some other, as-yet-undefined accountability measures in future. However, the Deputy Premier, the Minister of Health and Long-Term Care, was later quoted as saying she "wouldn't close the door on the Ombudsman" as a means of addressing complaints in the health and long-term care system.

Political wrangling aside, there is simply no well-articulated, rational justification for barring Ombudsman oversight in the MUSH sector. Sadly, it seems that "anybody but the Ombudsman" is the rallying cry for some government insiders. Perhaps the most vehement and fever-pitched example of this came from Transportation Minister Glen Murray, who spoke heatedly against Bill 42's proposal to extend Ombudsman oversight to children's aid societies, saying such cases require sensitivity and prudence:

> "The Ombudsman is someone who is on the front page of the paper, whose tactics are to advocate for an individual, and hardly an office that shows that kind of discretion."
>
> From *Hansard*, April 11, 2013

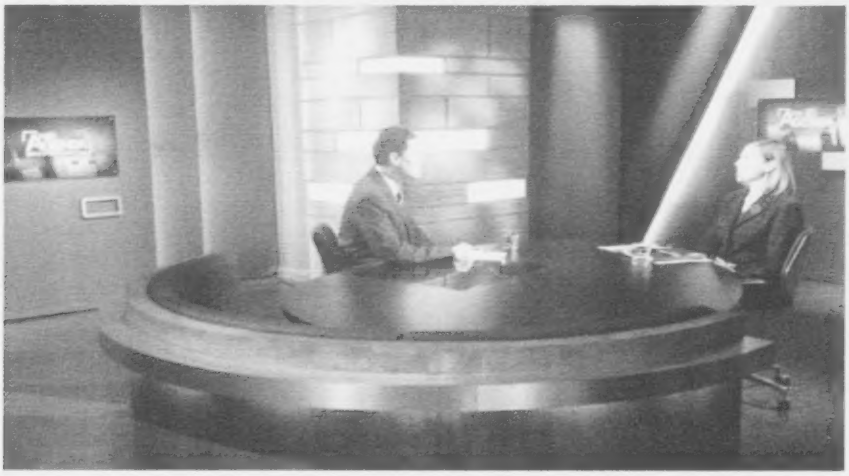
The Minister later apologized for this inaccurate public attack on my Office's integrity.

The fact is, since I took office in April 2005, I have deliberately worked to enhance public awareness of the Ombudsman's Office and how it can assist Ontarians. It is through demonstrating our value openly, often and in clear language, that we have been able to influence positive changes in the law, policy and practices for the benefit of Ontario's citizens.

When I issue official reports, answer journalists' questions or use social media, I am using the tools at my disposal to get the job done as effectively as possible, just as a carpenter uses a hammer. The style of our reports, the compelling personal stories that are included, and the clear language of our communications all help engage the interest and imagination of citizens and legislators, which is essential for an office that relies on both public input and political will to spark systemic reforms.

Our approach has not only allowed us to achieve results for the thousands of people who come to us confidentially – it has also been emulated around the world by the hundreds of watchdog organizations that have sent their staff to us for training.

More on this can be found in the **Communications and Outreach** and **Training and Consultation** sections of this report.



Deputy Ombudsman Barbara Finlay appears with host Steve Paikin on TVO's *The Agenda* to discuss *In the Line of Duty*, November 6, 2012.

Hospital horrors

Ontarians put their faith in hospitals to treat the sick and injured with competence, sensitivity, and professionalism. Regrettably, a year does not go by without some systemic scandal erupting in the hospital sector, whether it is an outbreak of *C. difficile*, prolonged emergency room wait times, or this year's controversy over monitoring of chemotherapy doses for cancer patients.

In 2012-2013, according to news reports, a 22-year-old man lapsed into a coma, 12 hours after being released with head injuries from Toronto Western Hospital. An 82-year-old grandmother died at Mount Sinai Hospital after falling out of bed unsupervised. A newborn baby at Humber River Regional Hospital was pronounced dead, only to be discovered alive some 90 minutes later.

Hospitals routinely respond to these horrific cases by launching internal inquiries. Typically, the results of these reviews remain confidential, leaving the public with unanswered questions and diminished confidence in the health care system. Unlike every other province in Canada, Ontario has left its 150 hospital corporations immune from Ombudsman oversight.

Internal patient relations officials owe their allegiance to their employers and do not have the means or the will to carry out credible independent investigations or report on maladministration. Consider the recent news story of the 80-year-old patient of the London Health Sciences Centre who claims he was told to clean his own messy toilet – and was chastised by an official in the hospital's complaints department for going to the media. The hospital officially denied the report, but without an independent, impartial inquiry, the truth will never be confirmed. And even if existing internal complaint mechanisms are enhanced, as the Premier has implied they might be, they will not replace the need for external investigative oversight under the *Ombudsman Act*.

Our Office has the unique ability to observe systems holistically and identify trends and best practices. We have the statutory powers, the experience, and proven track record of success to promote necessary changes.

This past year, the Ontario Hospital Association board of directors considered proposals to extend my Office's mandate to hospitals. While there may be some angst expressed about this prospect, I believe with time there may also be acceptance. In cases where government has taken over hospitals by appointing supervisors (thereby giving us temporary oversight of those facilities), we have always worked productively with these officials. Not only do we assist citizens in resolving concerns, we are also a safety valve for often beleaguered administrators, who can refer cases to us to facilitate resolution. In our experience, citizens are much more likely to accept our assessment that administrators have acted reasonably or lawfully than to take the word of involved officials.

Long-term care lapses

Ontario will soon be the only province whose Ombudsman has no authority to investigate long-term care homes, leaving the 76,000 residents of some 640 homes with no recourse to independent oversight. The only other holdout, New Brunswick, has passed new legislation and will soon extend its ombudsman's mandate.

As with hospitals, we continue to hear nightmare tales of abuse and neglect arising from Ontario long-term care homes, but are powerless to act. Among the many stories that made headlines, an 87-year-old woman was trapped in an out-of-service elevator in a long-term care centre in Mississauga for more than 29 hours. A 72-year-old woman was beaten to death, and a 91-year-old assaulted, by a fellow resident in a Scarborough long-term care home.

And Camille Parent, concerned about his 85-year-old mother's unexplained injuries, hid a video camera in her room at a long-term care home in Peterborough. The video revealed egregious, degrading treatment by several workers, who have since been fired. The Ministry of Health and Long-Term Care launched an investigation, but Mr. Parent said he would prefer independent oversight:

"Number one thing I'd like to see is the Ombudsman get involved and take the whole investigation away from the Crown."

Camille Parent, speaking to CTV National News, May 19, 2013

Ornge air ambulances – flying out of reach

Ornge is a federally incorporated non-profit company. As such, it does not come within my jurisdiction. But Ornge carries out an essential public service, transporting about 18,000 patients each year by land and air ambulance, and receiving $150 million in taxpayer dollars annually to do so.

Since 2005, my Office has received **29** complaints about Ornge – five of them from whistleblowers. The issues identified were extremely serious and reflective of the flagrant breach of public trust committed by Ornge administrators, the extent of which only came to light in December 2011. **Twelve** of these complaints were received in 2012-2013, including claims of inadequate equipment maintenance and inspection, and problematic dispatch practices.

Over the years, we have heard complaints about the purchase of inappropriate helicopters, stonewalling of investigators, poor service, inadequate infection control, misappropriation of funds, muzzling of Ornge staff and conflicts of interest involving Ornge administrators. We referred complainants to the Ministry of Health and Long-Term Care or the Auditor General when appropriate, although many expressed dissatisfaction with the quality of the Ministry's supervision of Ornge. Had we been able to delve into the issues they raised, we might have been able to address some of the problematic practices that were eventually uncovered.

On May 15, 2013, I was invited to speak to the Standing Committee on General Government about Bill 11, the *Ambulance Amendment Act (Air Ambulances), 2013*. The bill calls for increased accountability measures relating to designated air ambulance service providers like Ornge.

During my presentation, I observed that it is not sufficient to replace the truly independent external oversight that the Ombudsman's Office provides with the "innersight" of internal mechanisms. Ornge's own history demonstrates this dramatically, and new accountability measures so far have fallen short.

Ombudsman André Marin and Deputy Ombudsman Barbara Finlay appear before the Standing Committee on General Government regarding Bill 11 and oversight of Ornge, May 15, 2013.

> "Now, what's wrong with Bill 11? Nothing – and everything. It consists of an elaborate series of baby steps that will improve internal checks and balances – not a bad thing, but falling short of true oversight. We are ahead by a few yards, but far from a touchdown."
>
> Ombudsman André Marin, submission to the Standing Committee on General Government, May 15, 2013

Ornge's new Patient Advocate, for example, is a staff position, responsible for dealing with "compliments" and complaints. Similar to patient relations staff in hospitals, this individual is an employee without any effective authority. While internal complaints processes serve a useful purpose, they are a poor substitute for an independent parliamentary Ombudsman with robust powers of investigation and public reporting. Bill 11 proposes authorizing government to appoint special investigators – but again, they would report through the Ministry.

The Ombudsman is the watchdog for the elected members of the Legislative Assembly and an advocate for fairness, not the Ministry's pet on a ministerial leash.

The Auditor General was given the ability to monitor Ornge's finances and the Information and Privacy Commissioner will soon have authority over related information and privacy issues. There is no justification for denying potential complainants recourse to my Office as well, which performs a complementary but entirely separate role from these officers.

Give us a "C" – children's aid societies

The province of Ontario is the legal guardian to more than **8,300** children and youth connected to child protection services, which are delivered by **46** independent, non-profit organizations run by locally elected boards of directors. Protection of children is a grave responsibility, and one that everywhere else in Canada is carried out by government. Ontario's system is unique.

Since 2005, my Office has received **3,550** complaints and inquiries about children's aid societies. Ontario's children's aid societies receive provincial funds in excess of **$1.4** billion each year, but since they are considered private agencies, they fall outside of my mandate.

Media stories chronicling the deaths and abuse suffered by children involved with Ontario's child protection system have inspired advocacy groups and successive parliamentarians to call for Ombudsman oversight of children's aid societies. Since April 2005, some **60** petitions and **7** private member's bills have been tabled in the Legislative Assembly to this effect. Support for Ombudsman involvement in this area is strong, as evidenced by NDP MPP Monique Taylor's Bill 42, the *Ombudsman Amendment Act (Children's Aid Societies), 2013*, passing second reading in April 2013.

Within the child welfare community, the possibility of Ombudsman oversight is a live issue. This was evident this year, when our Office was asked to do a presentation for the Ontario Association of Children's Aid Societies on what Ombudsman oversight might mean for them.

The argument against Ombudsman oversight of children's aid societies has always been feeble. None of the existing oversight mechanisms – the Ministry of Children and Youth Services, the Provincial Advocate for Children and Youth, the Child and Family Services Review Board, the courts, the Office of the Chief Coroner and the Pediatric Death Review Committee – provide for broad-based investigation into systemic and individual issues of fairness and administration. What's more, the latter two only become involved after a child dies.

Admittedly, Ombudsman oversight is not a cure-all. But it is a powerful and proven method for promoting accountability and transparency. As we do for hundreds of other provincial organizations, my Office can act as an early warning system, proactively monitor complaint trends, expose systemic flaws and obtain speedy resolutions, before a crisis hits. This important resource should not be barred to children and youth in care, their families, and concerned members of the public.

> "I know it's too late for me, but I want future generations to be protected..... There are too many kids being abused and nobody is being held accountable for it. The Ombudsman should be able to investigate this."
>
> Former CAS ward who was abused by foster father, quoted in the *Toronto Sun*, March 21, 2013

Children's aid societies in Ontario also face serious financial pressures, and there is growing recognition that the system requires an overhaul. In recognition of the public funding that they receive, they are already subject to financial monitoring by the Auditor General. The time is ripe to make them accountable to the Ombudsman as well, to give vulnerable children in care and their families the same access to independent oversight as those involved with provincial agencies.

OMLET still cooking

Although municipalities remain outside of my Office's mandate, we are the investigator for complaints about closed municipal meetings in all municipalities that have not appointed their own investigators. In 2012-2013, our Open Meeting Law Enforcement Team (OMLET) – which investigates whether municipalities have complied with the open meeting requirements of the *Municipal Act, 2001* – dealt with **305** complaints, more than double last year's **119**. Due to the volume of these cases, I released my first separate OMLET Annual Report in October 2012. I will release my next one this coming fall. Among the issues it will address are the legislative loophole that allows municipalities to reject the independent oversight of my Office in favour of investigators of their choosing, and the lack of consequences for those that hold illegal closed meetings.

Closing Thoughts

Ombudsman oversight is an established, efficient, multipurpose accountability tool, effective in helping citizens navigate Ontario's government programs, policies and practices, shining light on unfairness and maladministration, and promoting positive systemic change and good governance.

I remain hopeful that, rather than resorting to inferior internal accountability devices, the government of Ontario will recognize the benefits of putting the Ombudsman's Office to use in all areas that sorely need our intervention.

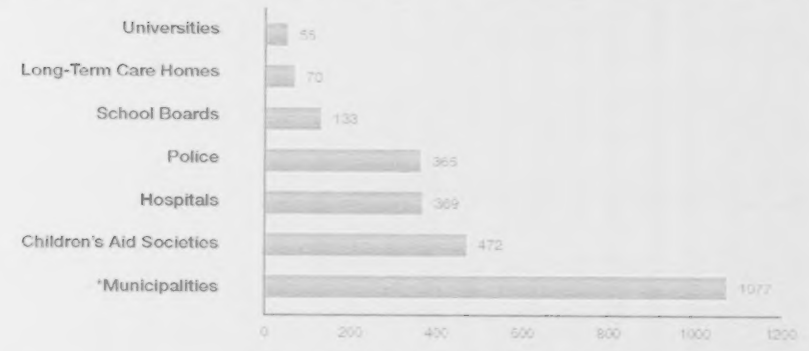
Ombudsman staff participated in a number of charitable events in 2012-2013, notably the Canadian Breast Cancer Foundation Run for the Cure in October (for breast cancer research) and Movember (for prostate cancer research and men's health awareness).

The Year in Review

Beyond Scrutiny: The push for MUSH

As the accompanying chart reflects, the Ombudsman received **2,541** complaints and inquiries in **2012-2013** about the **MUSH** sector, comprising **m**unicipalities, **u**niversities, **s**chool boards and **h**ospitals, as well as long-term care homes, children's aid societies and police. Although **MUSH** organizations deliver essential public services directly affecting Ontario citizens, they continue to operate without Ombudsman oversight – unlike in most other provinces. Ontario remains dead last in Canada in allowing its Ombudsman authority over this sector.

MUSH SECTOR CASES RECEIVED DURING FISCAL YEAR 2012-2013 **TOTAL: 2,541**



* Excludes cases received about closed municipal meetings

DEAD LAST
How Ontario's Ombudsman mandate compares to others in key areas of jurisdiction

	Municipalities	Universities	School Boards	Public Hospitals	Long-Term Care Homes	Child Protection Services	Police Complaints Review Mechanism
ONTARIO	NO	NO	NO	NO	NO	NO	NO
British Columbia	Yes	Yes	Yes	Yes	Yes	Yes	No
Alberta	No	No	No	Yes	Yes	Yes	Yes
Saskatchewan	No	No	No	Yes	Yes	Yes	Yes
Manitoba	Yes	No	No	Yes	Yes	Yes	Yes
Quebec	No	No	No	Yes	Yes	Yes	Yes
New Brunswick	Yes	No	Yes	Yes	No	Yes	Yes
Newfoundland and Labrador	No	Yes	Yes	Yes	Yes	Yes	Yes
Nova Scotia	Yes	No	Yes	Yes	Yes	Yes	Yes
Yukon	Yes	No	Yes	Yes	Yes	Yes	No

This situation reflects a serious accountability gap. Most MUSH agencies are subject to information and privacy legislation and financial oversight by the Auditor General. But Ontarians concerned about general maladministration and unfairness cannot complain to us about MUSH organizations – unlike the hundreds of other provincial bodies we do oversee.

This anomaly has not escaped the notice of citizens and parliamentarians. The push for Ombudsman oversight in the MUSH sector has continued to gain traction. Since 2005, some **14** private member's bills have called for Ombudsman scrutiny of various **MUSH** organizations. The most recent, Bill 42, the *Ombudsman Amendment Act (Children's Aid Societies), 2013*, introduced by NDP MPP Monique Taylor, was referred to the Standing Committee on Government Agencies after second reading on April 11, 2013. A previous version of this bill also received second reading, but died when the Legislature was prorogued in October 2012.

As well, a record **41** petitions calling for increased Ombudsman authority in the MUSH sector were presented in the Legislature in 2012-2013, bringing the total number of such petitions since 2005 to **106**.

Despite our limited mandate, our Office assists complainants with MUSH sector issues by referring them to help where possible. Although we cannot investigate them, we track the complaints and the issues raised, and summarize them each year in this report.

"M" – Municipalities

The City of Toronto remains the only municipality in the province with its own in-house Ombudsman. However, across the province, citizens have no recourse to external, independent investigative scrutiny of municipal matters.

While we can address complaints about improperly closed meetings for some **189** municipalities that use our services as a closed meeting investigator, we were forced to turn away **1,077** complaints and inquiries about other municipal issues.

These included living conditions in public housing, the calculation and collection of property taxes, sewer and water charges, the state of roads, parks and recreational facilities, the adequacy of bylaw enforcement, local procurement practices and garbage collection services, and allegations of conflicts of interest.

There are four provinces and one territory whose ombudsmen have the authority to investigate municipal matters. For example, in 2011-2012, the Ombudsman of Nova Scotia found nine municipalities had made unauthorized expenditures of public funds, and the B.C. Ombudsperson sparked a municipal bylaw change to ensure interested property owners were notified about proposed gravel pits.

"U" – Universities

In **2012-2013**, our Office received **55** complaints and inquiries about universities. Although colleges of applied arts and technology come within the Ombudsman's investigative authority, universities do not, because of their governance structure.

Students complained to us about a variety of issues including fees, the quality of instruction, internal academic appeals, complaint processes and grade disputes.

Two provincial ombudsmen have authority in this area. For example, in 2011-2012, the B.C. Ombudsperson's intervention led to a revised appeal policy for students facing suspension.

"S" – School Boards

We received **133** complaints and inquiries about Ontario school boards in 2012-2013, including concerns about student suspensions, lack of adequate special education supports, the use of "blocker shields" on students with autism, inadequate response to bullying, and busing problems.

Ombudsman offices in four provinces and one territory can deal with complaints about schools. For example, in 2011-2012, the Nova Scotia Ombudsman reviewed the process for selecting school bus stops, and the B.C. Ombudsperson helped improve a school district's process for responding to complaints about bullying.

Some Ontario school board officials have begun to recognize the value of Ombudsman oversight. In spring 2012, the Toronto Catholic District School Board considered (but later rejected) creating an independent third-party ombudsman. In 2013, a school trustee sought support from the Ottawa-Carleton District School Board to extend our Office's mandate to school boards, as well as other **MUSH** bodies, but was unsuccessful.

Under supervision: Although the Ombudsman does not normally have jurisdiction over school boards, that changes when the Ministry of Education appoints a supervisor to take control of a board. On August 28, 2012, it appointed a supervisor for the Windsor-Essex Catholic District School Board. We received **7** complaints about this board in 2012-2013, primarily about employment-related issues. We made regular inquiries with the supervisor to monitor the board's progress in implementing administrative improvements.

"H" – Hospitals

Our Office was forced to turn away **369** cases involving hospitals in 2012-2013. These covered an array of issues, including emergency room, surgery and cancer treatment wait times, billing practices, breaches of patient confidentiality, poor infection control, discharge planning, and inadequate communication.

Ontario is alone in barring its Ombudsman from considering complaints relating to hospitals. Meanwhile, Saskatchewan provided its Ombudsman with authority to review decisions of a broader range of publicly funded health entities in 2012, including some privately owned health care organizations. Other ombudsmen obtained concrete results for citizens who complained about hospital administration. For example, in 2011-2012, the Ombudsman of Nova Scotia tackled concerns about patient charting and autopsy report delays. The B.C. Ombudsperson's work led to improvements in a hospital's admission practices. Quebec's Ombudsman addressed emergency room wait times, quality of services in addiction treatment facilities, and the transfer of elderly residents to long-term care facilities in a bid to unclog a hospital's emergency services.

> "Your personal interest, the dedication of your management team, and the quality of your actions demonstrate – yet again – your commitment to work with complete impartiality in the defence of citizens' rights and to improve the quality of public services. I sincerely hope that this additional authority will be granted to the Ombudsman of Ontario."
>
> Quebec Ombudsman Raymonde Saint-Germain, letter to Ombudsman, April 2013

Quebec Ombudsman Raymonde Saint-Germain speaks to Ontario Ombudsman managers about her office's mandate to investigate hospitals, April 10, 2013.

And in the U.K., the Parliamentary and Health Service Ombudsman released a report about systemic problems in that country's hospitals in April 2013, after looking at 400 serious cases. The Ombudsman found that hospitals routinely treated patients and their families insensitively and without compassion.

But in Ontario, opponents to Ombudsman oversight continue to argue that it would duplicate such existing mechanisms as public reporting on patient safety measures, quality indicators and wait times, compliance with accreditation standards and accountability agreements, internal patient relations processes, freedom of information obligations and reviews by the Auditor General.

All of these measures have value, but they do not replace the need for Ombudsman oversight, nor do the "patient relations" officials at some 150 Ontario hospital corporations. Indeed, we continue to receive complaints about the internal complaints processes established by hospitals, particularly about their lack of responsiveness and objectivity. And while hospitals have been subject to the *Freedom of Information and Protection of Privacy Act* since 2012, quality of care information remains shielded from disclosure.

None of the existing accountability tools in the hospital sector provides recourse to an independent, external overseer with the Ombudsman's statutory mandate and powers to conduct impartial investigations of individual and systemic issues, publicize results, and exert moral suasion to correct unfairness and maladministration.

> "It's really troubling that there is no ombudsman for health-care issues in Ontario. If there was more accountability, we'd all be safer."
>
> Richard Kadziewicz, letter to *Toronto Star*, April 15, 2012

Under supervision: Our Office does have temporary jurisdiction to accept complaints about hospitals where the province has taken direct control and appointed a supervisor. The Hotel-Dieu Grace Hospital in Windsor was under supervision until July 20, 2012, and we received **2** complaints about it, which were resolved. The Niagara Health System also remained under supervision in 2012-2013 and was the subject of **31** cases received by our Office, a significant decrease from last year's **81**. These included concerns about poor communication, breach of privacy, inadequate response to complaints, and a need for repairs in some facilities. Our Office triaged all of these complaints, obtained relevant facts, and followed up with the supervisor where necessary.

Long-Term Care Homes

In **2012-2013**, our Office received **70** complaints and inquiries about Ontario's long-term care homes, most from relatives of residents concerned about everything from inadequate care and understaffing to poor record keeping and allegations of abuse. We could not directly investigate these issues, but referred complainants elsewhere when we could.

Ontario will soon be the only province whose Ombudsman has no oversight of long-term care homes – once New Brunswick's new legislation is implemented. Other ombudsmen have achieved significant results for their citizens in this area. For instance, in 2012, the Ombudsman of Saskatchewan addressed an unfair and rushed relocation of long-term care residents, and the B.C. Ombudsperson reported on a three-year investigation into the care of seniors, including recommendations designed to improve resident care. The same year, in Quebec, after an 83-year-old resident died in a special unit for individuals with dementia, the Ombudsman identified major flaws in living conditions and services, leading to corrective action.

Despite our lack of ability to investigate the homes themselves, our Office continues to follow up on our investigation into how the Ministry of Health and Long-Term Care monitors them. Details on this can be found in the **Special Ombudsman Response Team** section of this report.

> "Families that have witnessed inexcusable institutional neglect of their beloved parents, and horrific deaths of loved ones in nursing homes, understand the critical need for the provincial ombudsman's oversight over hospitals and long-term facilities."
>
> Ellen Watson, letter to *Toronto Sun*, January 24, 2013

Children's Aid Societies

This year, the Ombudsman received **472** complaints and inquiries about children's aid societies across the province. These came from youth in care, parents, grandparents and other people concerned about failures to investigate neglect and abuse, inadequate or biased investigations, problematic child apprehensions, staff misconduct and harassment, lack of information, and denial of access to children in care. In one case, a mother alleged her child was sexally abused by an older foster sibling. Several people also questioned the qualifications of children's aid society employees who operate without registration as social workers.

Unique in Canada, child welfare services in Ontario are delivered by private agencies. Everywhere else, child protection is administered directly by government. Other ombudsmen have been able to assist families with concerns about child protection. For instance, in March 2013, the Manitoba Ombudsman's Office released a report emphasizing the importance of risk assessment and case planning in the child welfare system. In Quebec, in 2011-2012, after a child was hospitalized with injuries allegedly caused by his parents, the Ombudsman's intervention led to enhanced screening to identify neglect and abuse.

In Ontario, defenders of the status quo routinely refer to existing mechanisms to review children's aid societies, such as the Ministry of Children and Youth Services, the Provincial Advocate for Children and Youth, the Child and Family Services Review Board, the courts, the Office of the Chief Coroner, and the Pediatric Death Review Committee. However, none of these bodies has the Ontario Ombudsman's broad statutory powers allowing for independent investigation of individual and systemic allegations of maladministration.

While the Child and Family Services Review Board received authority to consider complaints about children's aid societies in 2006, only those "seeking or receiving service" can request its assistance, leaving many relatives and concerned community members with no recourse. The Board is also restricted to considering procedural issues, such as whether a children's aid society provided reasons for its actions, listened to parents' concerns about services, or responded to a complaint. It cannot investigate or consider systemic issues involving staff conduct or practices, or address substantive matters relating to child apprehension or failure to investigate allegations of abuse. And its remedies are limited to ordering that a children's aid society respond or provide reasons.

In **2012-2013**, we received **4** complaints about the Child and Family Services Review Board, including concerns about its jurisdictional limitations.

> "[The Ombudsman] is a stellar investigator and has enormous integrity. His office is there for citizens as a mechanism to sort out problems with governments. He does not invent such problems, but tries to address them with recommendations. CAS oversight is long overdue, in some cases it is a matter of life and death."
>
> Anne Patterson, letter to *London Free Press*, March 23, 2013

Police

In **2012-2013**, the Ombudsman received **365** complaints and inquiries about police, including allegations of assault, wrongful detention and arrest, harassment and threats, inappropriate response to individuals suffering from mental illness, inadequate investigation, and improper discharge of a Taser. We also heard complaints about "carding" – police keeping information about people who were stopped but not arrested. These were referred to the Ministry of the Attorney General's Office of the Independent Police Review Director (OIPRD) or the Special Investigations Unit (SIU), where appropriate.

Seven provinces allow for Ombudsman oversight of police services. For instance, in 2011, the Manitoba Ombudsman reported on police detaining intoxicated youths in jails.

This year, we received **43** complaints and inquiries about the OIPRD, raising concerns about flawed communications, investigations and decisions. Under the *Police Services Act*, this body does not fall within our jurisdiction, even though the SIU does.

Operations Overview

The Ombudsman's Office received **19,726** complaints and inquiries in 2012-2013 – a **6%** increase from the previous year. Most (54%) complaints were resolved within one week; 66% were resolved within two weeks. The **Case Summaries** section of this report features examples of the many cases that were successfully resolved, often by our staff helping people who felt they were stuck in endless bureaucratic lines.

The Operations section of the Office, which consists of Early Resolution Officers and Investigators, focuses on resolving individual cases. Cases that cannot be informally resolved are referred for formal investigation, while others are brought to the attention of senior government officials and successfully addressed.

Both teams work closely with the **Special Ombudsman Response Team** (SORT) to identify and resolve potential systemic problems wherever possible. Senior Ombudsman staff also meet regularly with top officials from the most complained about ministries, organizations and programs to alert them to complaint trends and significant cases.

Complaint Trends and Significant Cases in 2012-2013

Ministry of the Attorney General

Office of the Public Guardian and Trustee

Among its other responsibilities, the Office of the Public Guardian and Trustee (OPGT) is responsible for managing the financial affairs of people who are incapable of doing so themselves. The Ombudsman received **162** complaints about the OPGT in 2012-2013, compared to 130 in 2011-2012. As in previous years, these complaints related primarily to problems with the OPGT's communication with clients, delays and the quality of service. Some complaints also involved OPGT decisions, such as refusals to provide clients with funds.

For example, OPGT staff inadvertently charged a man legal fees for its discussions with our Office about his complaint to us. They also attached an outdated fee schedule to the legal bill. When Ombudsman staff brought this to the attention of the OPGT, it ensured that the client was not charged for the discussions with our Office and it sent the client a current schedule for other fees.

Senior OPGT officials meet regularly with Ombudsman staff to discuss complaint trends, potential systemic issues and individual cases. The OPGT has continued to focus its efforts on improving customer service, an area the Ombudsman remains concerned about.

Ministry of Community Safety and Correctional Services

Correctional facilities – Complaints from inmates

Due to the consistently high number of complaints received from correctional institutions across the province, the Ombudsman's strategy is to focus resources on those involving serious health and safety issues. In addition to flagging complaints about excessive use of force by correctional officers (the subject of the Ombudsman's latest systemic report – see the **Special Ombudsman Response Team** section of this report), staff continue to monitor complaints about the handling of inmate-on-inmate assaults.

For example, we learned of two serious assaults at one institution, neither of which had been investigated by the facility's senior management. We brought these cases to the attention of senior officials at the Ministry, who ensured both assaults were investigated. The Assistant Deputy Minister also issued direction to the region's superintendents that a local investigation should be conducted into any assault that results in serious injury.

We also continue to receive a high volume of complaints from inmates about health-related issues, such as lack of access to medication, medical staff or treatment. Many complaints involve health care staff not communicating with community physicians, institutional doctors refusing to prescribe medications, missed or delayed medication due to lockdowns, and medication being cut off without an alternative. We also received a large number of complaints from inmates with serious mental illnesses who faced long waits to see a psychiatrist, and about a lack of services for female inmates with mental health issues.

In one case, a woman who was seven months pregnant had been in jail for more than three weeks without seeing a doctor. After Ombudsman staff spoke to the health care manager at the institution, arrangements were made for the woman to see a doctor and be transferred to the high-risk clinic in case she gave birth while in custody. In another case, an inmate who has epilepsy complained that his identification card did not note his condition and he was being made to sleep on an upper bunk; Ombudsman staff spoke with the relevant health care manager and both his bunk and ID card were changed. In a third case, an inmate complained that a nurse had given him another inmate's medication by mistake and he received a methadone overdose. Ombudsman staff followed up with the facility's superintendent, who confirmed the mistake and ensured the inmate's condition was monitored by a doctor. This latter case was also brought to the attention of senior Ministry officials.

In January 2013, an inmate at a detention centre complained to the Ombudsman after making three requests to see a psychiatrist. Ombudsman staff discovered that the facility had used up its psychiatry budget for the fiscal year and had reduced the psychiatrist's hours as a result, forcing staff to triage inmates' requests so that those in crisis were given priority. After Ombudsman staff spoke to the regional director about the situation, a quarterly budget review was implemented to ensure even distribution of psychiatric hours throughout the fiscal year. The regional director also directed all superintendents in the region to consult with her about budgetary concerns, and committed to providing regular updates to the Ombudsman's Office on this issue.

As we have done for several years now, senior Ombudsman staff meet with top Ministry officials on a quarterly basis to discuss trends in complaints and emerging systemic issues. We also meet directly with those responsible for health care services in correctional facilities to address issues and identify areas for further improvement.

Private Security and Investigative Services Branch

In recent years, Ombudsman staff have monitored complaints about the Ministry's Private Security and Investigative Services Branch, which is responsible for licensing private investigators and security guards, as well as handling complaints made against them.

Last year, we reported that in response to concerns raised by Ombudsman staff, the branch overhauled its complaint process. It has also cleared the backlog of 200 complaints that accumulated while the new process was being developed.

This year, Ombudsman staff identified concerns to the Ministry about delays caused by the branch's practice of returning incomplete licence applications and renewals to applicants by mail without attempting to contact them to resolve problems. The Ministry made improvements and as of April 2013, applications could be made and their status checked by applicants online. The Ombudsman will continue to monitor complaints received about the branch.

Ombudsman staff show employees of the Death Investigation Oversight Council elements of our complaint handling process, February 14, 2013.

Death Investigation Oversight Council

The Death Investigation Oversight Council (DIOC) was established in December 2010 to oversee the work of Ontario's coroners and forensic pathologists. It advises the Chief Coroner and Chief Forensic Pathologist on key issues, and can receive complaints about these organizations' work through its complaints committee.

After receiving complaints about the DIOC's customer service and confusion about its role, senior Ombudsman staff met with the chair to discuss ways to improve the transparency and accessibility of the DIOC's complaint process. It was suggested that the DIOC should provide clear, evidence-based reasons in its decision letters, improve communication with complainants, and ensure its role and mandate are clearly set out in its public materials and website. The chair, who has worked proactively with our Office to address issues, agreed and changes were made to the website and DIOC correspondence. As well, the DIOC can now be contacted directly by phone.

Senior Ombudsman staff also provided an information session on the Ombudsman's mandate and operations to DIOC staff and shared some of our best practices for complaint handling.

Ontario Forensic Pathology Service – Historically retained organs

The Ontario Forensic Pathology Service (OFPS) office works closely with the Office of the Chief Coroner with regard to death investigations in the public interest. The Ombudsman received **5** complaints after the Ministry of Community Safety and Correctional Services issued a press release in June 2012 revealing that it had stored organs from autopsies conducted by the coroner's office prior to 2010. The Ministry called on affected families to advise how they wanted their loved ones' remains to be dealt with. Many were upset that this practice had never been public knowledge.

Our Office connected the families who complained with officials at the office of the Chief Coroner and at the OFPS who could provide information and answers. We have not received any further complaints since August 2012.

The Chief Forensic Pathologist also met with the Ombudsman to explain why organs had been retained after autopsies in the past, and to outline how affected families were being informed. He noted that regulatory changes were made to ensure families would be informed about organ retention in future. As of mid-April 2013, the Chief Forensic Pathologist's office advised us that it had been contacted by 2,500 families out of a potential 4,000 who could come forward. While the Ombudsman will continue to monitor this issue, he advised the Minister that we have received positive feedback from affected families, and good co-operation from the Chief Forensic Pathologist.

Ministry of Community and Social Services

Family Responsibility Office

The Family Responsibility Office (FRO) is responsible for the enforcement of court-ordered child and spousal support in Ontario. Our Office received **794** complaints about the FRO in 2012-2013, making it once again the most complained about Ontario government organization. Complaints commonly involve inadequate or delayed enforcement of support orders or insufficient communication with clients.

Similar complaint trends were observed this year, such as FRO staff failing to review documentation, consider all available facts or ensure records are up to date before taking enforcement action for unpaid support. Another frequent complaint involved enforcement actions not in compliance with FRO policies and procedures.

We received many complaints about wide variations in when and how FRO staff chose to take enforcement action. In one case, FRO staff repeatedly negotiated new payment schedules with a man who had breached previous ones and owed more than $20,000 in arrears. FRO policy requires aggressive enforcement (driver's licence suspension, garnishing wages, etc.) when such schedules are violated. It wasn't until Ombudsman staff contacted FRO management about the case that the man was told aggressive enforcement would begin – whereupon he began making support payments.

Poor record keeping and administrative errors are persistent problems for the FRO, sometimes resulting in serious financial impact on clients. For instance, it erroneously paid nearly $34,000 of a woman's child support payments to a generic Ministry account from 1996 to 2007. The woman, who had been on social assistance in 1997 for 10 months, had assigned her child support payments from the FRO to the Ministry. However, the payments were never redirected to her when she came off social assistance, and she missed out on them for 11 years. After Ombudsman staff intervened, the FRO reimbursed her for the full amount.

Senior FRO managers meet regularly with our Office and have been very responsive to the complaint trends and cases brought to their attention. The FRO implemented a new case management computer system in April 2013 that will automate several of its manual processes and is expected to improve service. The Ombudsman remains optimistic about the proactive measures and strategies implemented by the FRO to address problems, but continues to be concerned about the themes arising from complaints.

Services for adults with developmental disabilities

In 2011-2012, the Ombudsman reported on serious, persistent complaints about the apparent lack of services to support young people with severe developmental disabilities once they turn 18 and are no longer cared for through the Ministry of Children and Youth Services. Ombudsman staff worked closely with the Ministry of Community and Social Services to resolve these cases one at a time, but complaints continued to mount. On November 29, 2012, the Ombudsman announced a systemic investigation into provincial services for adults with developmental disabilities who were in crisis situations. At that time, our Office had received **64** such complaints, but several hundred more came in after the investigation was announced. More details on this ongoing investigation can be found in the **Special Ombudsman Response Team** section of this report.

While the systemic investigation was under way, a team of Ombudsman staff was assigned to deal with individual cases and help families find immediate solutions. This involved following up where warranted with community agencies, Developmental Services Ontario (DSO) offices and Ministry staff.

In one such case, a young man with a developmental disability assaulted his widowed grandmother at a hospital and was involuntarily committed to the psychiatric unit. When his condition stabilized, the grandmother felt she could not take him home from hospital because she could not manage him. Ombudsman staff facilitated communication between the Ministry (including senior officials), the hospital and the local DSO office. After seven months, a "temporary safe bed" was found for the man at a group home – with the possibility to become a permanent placement – and his grandmother was very grateful for the help she received.

In another case, we were contacted by a family whose developmentally disabled 18-year-old son had been suspended from school for assaulting a teacher and several caregivers. He had also been violent at home and they had called the police for help. Ombudsman staff alerted the Ministry to the urgency of the case and it immediately arranged for home services for the family and sought a residential placement for the man on an urgent basis. Two months later, his family advised our Office that the Ministry had found a suitable residential placement for him in a group home and service providers had developed a plan to stabilize his behaviour and have him return to school.

Ombudsman staff continue to work to resolve the hundreds of individual complaints in this area as the investigation into the broader issues wraps up.

> "I am writing ... to acknowledge the excellent service recently received from the Office of the Ombudsman of Ontario. Their follow-through with Developmental Services Ontario resulted in an outcome ... that will most certainly enhance the quality of my [son's] life throughout his adult years... We now have much greater peace of mind."
>
> Letter to Ombudsman from mother of young man with developmental disabilities, February 2013

Thistletown Regional Centre

Thistletown Regional Centre is a Ministry-operated mental health centre that offers specialized services and community supports to children, youth and families with complex special needs and developmental challenges. It also provides residential care for 13 adults, some of whom have been living at the centre since early childhood or adolescence and are now middle-aged.

The Ombudsman was contacted by six families with adult relatives living at Thistletown. They were informed by letter in March 2012 that the centre would be closed and the residents relocated by March 31, 2013. They complained to the Ombudsman about this decision and the transition process.

Our review focused on the transition process and the parents' complaints that their calls were not returned or they were provided with inaccurate or inadequate information. Some said the profile setting out their loved ones' needs did not reflect the complex medical, behavioral or historical information in the recommendations made by the clinicians who had worked closely with them. They also wanted to know if there were any contingency plans if the new placement failed.

Ombudsman staff also found it difficult to obtain concrete information from the Thistletown transition team. After we expressed concerns to several senior Ministry officials, the Minsitry committed to improve communication with the families, and confirmed the residents would remain at Thistletown while new placements for them are found. At the time of writing this report, Thistletown remains open and Ombudsman staff continue to monitor this process.

Ministry of Children and Youth Services

Services for children with special needs

In 2011-2012, the Ombudsman reported **47** complaints about services and treatment for children with special needs. This increased to **91** complaints in 2012-2013 – representing an increase of **94%**. In the wake of the Ombudsman's investigation into services for adults with developmental disabilities who are in crisis, we heard from **60** families who were concerned about the services available to children as well. Many also worried about what services would be available when these children turned 18. Common complaints included a lack of service co-ordination (meaning families must deal with multiple applications and paperwork for different programs such as Special Services at Home and Assistance for Children with Severe Disabilities), and long waiting lists for services and programs such as respite for caregivers.

Ombudsman staff worked with community agencies and the relevant ministries to help families connect with the appropriate service providers and to resolve these cases as effectively as possible.

Two of these cases echoed the issues raised in the Ombudsman's 2005 investigation and report, *Between a Rock and a Hard Place*, which revealed parents were being forced to surrender custody of their children to children's aid societies in order to place them in facilities that could care for them. Ombudsman staff resolved both of these cases. More details can be found in the **Special Ombudsman Response Team** section of this report.

Assistance for Children with Severe Disabilities benefit program

In 2010-2011, the Ombudsman reported on complaints from families who were denied the Assistance for Children with Severe Disabilities (ACSD) benefit purely on the basis of income. Our inquiries prompted the Ministry to review how its officials were applying the eligibility requirements for the benefit, particularly the "extreme hardship" clause. This clause allowed them discretion to approve ACSD benefits for families whose income exceeded the Ministry's ceiling if they had incurred extreme costs relating to a child's disability. The Ministry found that the criteria were not being applied consistently and took steps to clarify the rules for its staff. As a result, more families received the benefit under the "extreme hardship" criteria.

The Ministry remained in contact with our Office on this matter and in 2012-2013, we received **5** complaints about such issues as delays in processing applications and failure to give notification of the suspension of ACSD benefits.

In one case, the mother of a severely disabled boy who had been receiving ACSD for several years assumed that when he turned 18, he would be eligible for benefits under the Ontario Disability Support Program (ODSP). She thought a letter from her son's doctor to the ACSD special agreements officer was all that was required, but when she later called the ODSP office for an update, she was told there was no record of an application on her son's behalf. With the help of her MPP, she submitted an application, but her son died just days before it was approved. Ombudsman staff discussed the circumstances surrounding the delayed application with senior staff at the Ministry of Community and Social Services and the Ministry of Children and Youth Services. The local ODSP office reviewed the case and subsequently agreed to provide the mother with **$2,273** in retroactive benefits. The Ministry also put protocols in place requiring that information about ODSP be provided to the family of any child receiving ACSD six months prior to the child's 18th birthday. Applications from ACSD clients for ODSP are now triaged and flagged immediately and put through an expedited approval process.

Ministry of Energy

Hydro One

Hydro One complaints to our Office increased from **232** in 2011-2012 to **328** in 2012-2013. The bulk of these were about disconnection notices and issues with so-called "smart meters" – the newer devices that have been rolled out across the province in recent years. In many cases, customers complained of receiving "estimated usage" bills that did not accurately reflect their power use, followed by large "catch-up" bills. Some also complained that "smart meters" were installed or replaced without their knowledge. Ombudsman staff brought individual cases to the attention of Hydro One officials, who agreed to provide explanations to customers and to make payment arrangements with them as warranted. We are closely monitoring Hydro One's progress in addressing these issues.

The Ombudsman also continues to receive complaints about excessive or incorrect billing by Hydro One. Ombudsman staff work with Hydro One staff to resolve these issues, and to facilitate discussions with customers to explain charges and accounting. Examples of individual case resolutions can be found in the **Case Summaries** section of this report.

Ministry of Health and Long-Term Care

Community Care Access Centre co-ordination

The Ombudsman was contacted by a lawyer on behalf of a 37-year-old woman with an acquired brain injury who was unable to care for herself. The woman was in a rehabilitation hospital awaiting a residential placement in a long-term care facility, when she was arrested in connection with an altercation at the hospital and jailed. It was unclear which government or community agency was responsible for the woman's care and placement; Ombudsman staff made more than a dozen calls to various government organizations in order to obtain information about her history.

Ombudsman staff contacted two regional Community Care Access Centres (responsible for co-ordinating various home and community care services) as well as several programs under the Ministry of Health and Long-Term Care and the Office of the Public Guardian and Trustee, in an effort to co-ordinate information between the agencies that had lost touch with the woman when she was incarcerated. After seven months in jail, she was released to a family member, who registered her with another regional CCAC to find an appropriate residential placement for her. She has since been back in both jail and hospital, however, Ombudsman staff and officials at the Ministry of Health and Long-Term Care are keeping a close eye on her case.

Out-of-country genetic testing

Two families contacted the Ombudsman when they were unable to obtain out-of-country funding for genetic testing on tissue from deceased relatives – even though the testing had been recommended by specialists. In the first case, a physician for a 14-year-old boy who died suddenly while playing sports recommended genetic testing to see if his surviving siblings had the same undiagnosed connective tissue disorder believed to have caused the boy's death. The Ministry initially denied funding for the test because the boy was deceased and therefore not covered by OHIP. However, the Health Services Appeal and Review Board agreed to order the test on behalf of the mother, who was covered by OHIP.

In the second case, a widowed mother sought out-of-country funding to pay for genetic testing of tissue from her deceased husband, who also died of a connective tissue disorder. The woman wanted the test to determine whether the couple's five-year-old daughter had the same condition, but her doctor did not request it because the Ministry had advised geneticists that it would not approve such requests.

Ministry officials initially told Ombudsman staff they would review their policy on such testing in light of the first appeal – but that similar requests in the meantime would be denied and would have to be appealed. When they provided no timeline for the review, we met with more senior representatives, after which the Ministry confirmed it would consult with the Chief Forensic Pathologist on the issue – and that new applications in the interim would be reviewed on a case-by-case basis. The Ombudsman will continue to monitor the Ministry's progress in this area.

Ministry of Government Services / Ministry of Health and Long-Term Care

Long-Term Care ACTION Line

The Long-Term Care ACTION Line was established for residents of long-term care homes to report concerns about care and services provided by their residence or Community Care Access Centre. It is operated by ServiceOntario. Staff at the phone line are to record information, ask questions, assess the problem and give the information to the Ministry or the relevant Community Care Access Centre for follow-up.

A long-term care home worker complained to the Ombudsman that she did not hear back after she reported a serious incident on the ACTION line. When Ombudsman staff asked Ministry officials about the call, it was discovered to be one of many that had been dropped from the computer system because the data had been entered improperly. The Ombudsman's inquiry revealed that this problem meant **260** calls were not acted upon as required.

The Ministry agreed to look into the matter to determine whether any data from the calls could be retrieved and to follow up as warranted. It will also update the Ombudsman on how it ensures calls to the ACTION line are properly handled and acted upon.

Ministry of Natural Resources

Natural Heritage, Lands, and Protected Spaces Branch

Ontario's *Aggregate Resources Act* controls and regulates aggregate operations (aggregates are defined as gravel, sand, clay, earth, several types of stone, or any combination of sand, gravel or stone). Aggregates are used primarily in construction projects. Under the Act, aggregate business operators in designated geographic areas are subject to a system of licensing, monitoring, inspection and enforcement, and annual licensing fees and costs.

A licenced aggregate operator from an area that was designated in 2007 complained to the Ombudsman that it was unfair not to subject all aggregate producers in the province to the same rules. He complained that operators in designated areas are at a competitive disadvantage when bidding for contracts against unlicenced operators from neighbouring non-designated areas because the unlicenced operators are not subject to the same licensing costs and requirements.

The Ministry advised the Ombudsman that it was developing options to address this inequity. In March 2012, the Standing Committee on General Government was directed by the Legislature to review and develop recommendations to strengthen the *Aggregate Resources Act*, and the Ministry's aggregate policy initiatives were put on hold pending the outcome of this review.

After the prorogation of the Legislative Assembly in October 2012, Ombudsman staff met with senior Ministry officials on this matter. In January 2013, the Ministry said it would continue to seek direction from the government to address this inequity.

Ministry of Training, Colleges and Universities

Private Career Colleges Branch

The Ministry's Private Career Colleges Branch is responsible for ensuring all private career colleges are in compliance with legislation and taking enforcement action against those that are unregistered or otherwise break the rules.

In 2012-2013, the Ombudsman received **19** complaints about this branch, down from **26** in the previous year. Complaints involved inadequate communication, unfair enforcement or delays in approving programs, renewing school registrations or responding to college compliance efforts.

One college director complained she waited several months for the Ministry to approve distance education courses. When Ombudsman staff brought this concern to senior managers, we learned the branch had concerns about the quality of its own process for approving such programs. It had stopped reviewing applications in October 2010. We monitored the branch's progress in developing a new policy framework, and in November 2012, the Ministry issued a new policy directive and resumed evaluating applications for such programs.

Ombudsman staff also spoke to the Deputy Minister about difficulty in obtaining information and timely responses from the Ministry on several cases. The Deputy Minister agreed to review one case personally and supported our Office's offer to meet with senior Ministry staff on a quarterly basis to discuss progress on complaints and issues. One such meeting had been held at the time of writing this report, to discuss complaint trends and what is expected when Ombudsman staff call the Ministry for information. Ministry staff committed to making improvements, and we continue to monitor complaints about this branch.

Ministry of Transportation

Licensing Service Branch – "Ghost" licences

In 2011-2012, the Ombudsman reported that a complaint from a man convicted of drunk driving led our staff to discover a disturbing issue with thousands of "master licence" records at the Ministry of Transportation. Master licence records are used by the Ministry to store information provided by the police and courts about an offence or information from a doctor about a driver's medical condition where no existing driver's licence for the person can be found – for example, when someone without an Ontario licence is stopped by the police or in an accident.

Once a "master" record is created, it is supposed to be matched with the driver's official licence, if one exists. However, if the information received by the Ministry does not exactly match that on the existing driver's licence, this can result in more than one licence record for the same person. In the case of the drunk driver, for example, because his surname was misspelled by one letter, his licence was not found in the system and a "master" one was created. His conviction and prohibition from driving were added to the "master" record, but his existing licence remained clear – and so he kept using it to drive.

In releasing his report last year, the Ombudsman said he was very concerned about the number of "ghost licences" and their potential impact on public safety. He reported that the Ministry was improving its search tools to catch potential duplicate licences resulting from misspelled names or addresses, but it had no plan to review all existing master licence records.

Ombudsman staff worked closely with the Ministry on this issue. It was determined more than **1.1 million** master licence records had been created since 1966. Some 235,000 related to Ontario residents; the rest were created in order to enter information about out-of-province drivers into the Ontario system.

The Ministry has since taken specific steps to identify potential "ghost licences." Its initial review identified **13,866** potential duplicate records for Ontario residents – **1,050** of which had been flagged for suspension. These are being reviewed in stages, starting with those that involve Criminal Code suspensions – because if these people are still driving, they pose the highest risk to public safety. At the time of writing this report, the Ministry had identified **138** high-risk potential duplicate master licence records. Of those, **100** were confirmed to be duplicates of driver's licences already in the Ministry's database. The Ministry confirmed that **35** of the **100** duplicate licences should have been suspended but were not, and these drivers could still be on the road. The Ministry is notifying them of their licence suspensions. Next, it will review the **647** duplicate master licence records it identified for people whose licences were suspended for medical reasons.

The Ministry of Finance's Internal Audit Division is also conducting an independent audit of the licensing control system to assess the process and conditions that led to the creation of master licences, the risk factors associated with them, and potential short- and long-term goals for the Ministry to monitor and reconcile duplicate records.

The Ministry has demonstrated that it takes the Ombudsman's concerns seriously. Senior Ministry officials have welcomed regular meetings with Ombudsman staff to discuss their progress as monitoring of this issue continues.

Training and Consultation

The Ombudsman's Office shares its expertise in complaint resolution and systemic investigations with other agencies from around the world. Since 2007, the Ombudsman's course **"Sharpening Your Teeth: Advanced Investigative Training for Administrative Watchdogs"** has been delivered to hundreds of ombudsmen, investigators and others in the oversight field, always on a cost-recovery basis. The Ombudsman and senior staff are also frequently asked to consult with and address various agencies and their representatives.

Training

In November 2012, the Ombudsman and Sue Haslam, Director of Investigations, were invited to deliver "Sharpening Your Teeth" training to more than 80 participants from around the world at the International Ombudsman Institute's 10th annual world conference in Wellington, New Zealand. Customized versions of the course were also conducted for the Office of the Citizen's Aide/Ombudsman of Iowa, for staff of the Ontario Fire Marshal and Ontario Energy Board, and for representatives of several countries at the Second Curaçao International Ombudsman Conference.

> "Thank you for the contribution you made with the outstanding success of 'Sharpening Your Teeth' [at the IOI World Conference in New Zealand]. Feedback on the SYT workshop demonstrated that you made a great impact and that what you had to say was, in a very real sense, life-changing for many. You certainly helped me to cement in the changes we are making to our own approach to investigations."
>
> Dame Beverley Wakem, President of the International Ombudsman Institute and Chief Ombudsman of New Zealand, letter to Ombudsman Marin, December 2012

The Ombudsman's annual "Sharpening Your Teeth" course in Toronto, held January 21-23, 2013, was the largest yet, with 80 participants from five continents. They included representatives from Brazil, Thailand, Kenya, the U.S., and the U.K., and agencies such as the Yukon Ombudsman's Office, the Alberta Ombudsman, Office of the New Brunswick Child and Youth Advocate, Office of the Métis Settlement Ombudsman, Health Canada, the Toronto Transit Commission, the Montreal Ombudsman's Office, the Retirement Homes Regulatory Authority, and the City of Toronto Ombudsman. Senior Ontario government officials in attendance represented the ministries of Environment, Aboriginal Affairs, Children and Youth Services, and the Ontario Provincial Police.

The 2013 edition of the course included a new session on using social media and technology in investigations and communications, as well as such core topics as investigation planning, interviewing witnesses, assessing evidence and writing and publicizing reports. For the first time, participants could also use an "SYT app" on their mobile phones to get the course schedule and location.

Special guest Peter Wallace, Secretary of the Ontario Cabinet and head of the Ontario public service, gave the keynote speech, emphasizing the importance of government watchdogs.

> "Your roles were set up for an absolutely vital reason, which is to ensure the public gets its value for money, to ensure the bureaucracy does not run amok, to ensure that there's a human face and human values put on those decisions. Our world is immensely better off because of the role of the Ombudsman [and other oversight offices]."
>
> Peter Wallace, Secretary of Cabinet and head of the Ontario Public Service, address to SYT participants, January 22, 2013

The next edition of "Sharpening Your Teeth" in Toronto will be held in January 2014.

Peter Wallace, Secretary of Cabinet and head of the Ontario Public Service, with Ombudsman André Marin at Sharpening Your Teeth, January 22, 2013.

Comments from SYT participants, January 2013

"An excellent investment with great returns."

Dr. Gavin McBurnie, Director of Operations (Business Development), Office of the U.K. Parliamentary and Health Services Ombudsman

"A wealth of information from a cutting edge organization. It is a standard to aspire to."

Stephen Hare, Health Canada

"This was an exceptional course; highly informative presentations, extremely engaging and obviously knowledgeable presenters."

Martin Hastings, Independent Electricity System Operator, Ontario

"The presenters were all engaging, dynamic and knowledgeable. Thank you very much for such a professional and high-level program."

Julie Smith, Trent University

"I have learned a lot of quality methods to implement in my work at home. I am excited to take some of these ideas, in particular best practices, social media presence, and writing styles."

Laura Pippenger, Assistant Ombudsman, Dayton-Montgomery County, Ohio

"The content is very useful in enhancing investigative skills for Ombudsman investigations. This is a very good program. Your team is very knowledgeable and impactful."

Micah Nzomo Nguli, Office of the Ombudsman of Kenya

Consultation with other agencies

The Ombudsman and staff are frequently asked to consult with other oversight agencies in Canada and around the world about everything from investigative methods to case management technology to the use of social media. Our senior staff also consult with and deliver presentations to officials from Ontario government ministries and organizations within our mandate – and occasionally in the MUSH sector as well.

In 2012-2013, for example, the Ombudsman and senior staff were invited to consult with, among others, the federal Victims of Crime Ombudsman, the national human rights commissioner of France, and visiting delegations from China's General Office of the State Council and Nigeria's commission on justice and corruption. They also delivered presentations to staff for the Office of the Integrity Commissioner, the Council of Elizabeth Fry Societies of Ontario, the Death Investigation Oversight Council, the Ontario Patient Relations Association and the Ontario Association of Children's Aid Societies. In addition, senior staff gave presentations via Skype and Google Hangouts, including to a conference of ombudsmen in Melbourne, Australia and a gathering of finance ministry employees from across Canada in Regina.

Ombudsman André Marin meets with a delegation from China's General Office of the State Council in August 2012, and with a delegation from the Office of the Ombudsman of Kenya, who attended Sharpening Your Teeth, January 2013.

Communications and Outreach

The Ombudsman makes communicating with the public a priority, and between new and traditional media, engagement with the public grew substantially in 2012-2013. From informal question-and-answer sessions on Twitter to in-person speeches and outreach events – several of which could also be viewed live on our website – the Ombudsman and staff employed new communications tools to promote the Office's work and to connect directly with the public, media and stakeholders.

> "Your accessibility via social media is a big strength. You are accountable, open & transparent to the people – your role, no?"
>
> @MariaVamvalis, via Twitter

Communications

The Ombudsman's high profile in the traditional news media is complemented by his social media presence, both of which help make the Office effective and have made it a leader in the ombudsman world. Similarly, the Office's published reports are complemented by constantly updated information on our website, mobile app, e-newsletter and social media activity.

Traditional media

There were **853** print articles published about the Ombudsman's Office in 2012-2013, primarily in daily newspapers across Ontario and the rest of Canada. The estimated advertising value of these articles was **$2.1 million**, reaching an aggregate audience of **52.7 million**, according to calculations by Infomart, based on newspaper advertising rates, circulation and page display. This represents an increase of 16% in audience reach and 23% in ad value over 2011-2012.

There were also **887** items about the Ombudsman and his work broadcast on radio and television, both in Ontario and across the country – a 125% increase over the previous year.

Social media

Social media tools have become integral to the Ombudsman's work, as the Office's following on Facebook, Twitter, YouTube, Flickr, and LinkedIn continues to grow. In 2012-2013, the Ombudsman was recognized for leadership in this area, both by other ombudsmen and by social media experts.

> "A thought leader in the trend toward open government, the Ombudsman has used Twitter successfully for: Accessibility; Transparency; Accountability."
>
> Thomley Fallis blog (thomleyfallis.ca), April 2013

In December 2012, the Ombudsman's **Twitter** account (**@Ont_Ombudsman** – all tweets are written by Ombudsman Marin personally unless otherwise noted) reached the milestone of 10,000 followers, and continued to climb, more than doubling last year's total. Events such as speeches and press conferences were live-tweeted with the hashtag **#OOLive** (OO for Ombudsman Ontario), making them easier to follow and search – and tweets were compiled as **Storify** stories. The Ombudsman also introduced casual question-and-answer sessions where he interacted with followers on some Sunday afternoons via the hashtag **#AskUrOmbuds**.

The Ombudsman's followers say his accessibility on Twitter has made them better informed about his role, and better able to interact with the Office. When he asked them "Should the Ombudsman be on Twitter?" he received more than 100 responses, almost all in the affirmative. The Ombudsman also uses Twitter to report procedural updates in investigations, link to announcements, press releases and relevant news stories, and post photos of his everyday work and life.

> "An O 'is charged with representing the interests of the public'...this is the perfect forum to learn and communicate with us!"
>
> @Jacydee, via Twitter

> "Accessibility, immediacy, accuracy, leadership, integrity, honesty, feedback, tips, information, clarity, input, tweet away!"
>
> @RossMcleanSec, via Twitter

> "Those who wonder why Ombudsman tweets, wonder why astronauts tweet. 2 best for-the-people accounts going."
>
> @helennarell, via Twitter

The Ombudsman's **Facebook** page increased its following by 25% in 2012-2013 and posts on the page reached more than **118,000** people. The page keeps followers informed with updates from the Ombudsman's investigations, photos and speeches from events or office visits, links to news stories, press releases and job postings. The most popular single post, which linked to a poll by the *Toronto Sun* about giving the Ombudsman oversight of the Children's Aid Societies, reached 5,100 people and was shared 92 times.

On **YouTube**, the Ombudsman's channel garnered thousands of new viewers, who watched videos of press conferences and speeches. There were about **19,200** views as of March 31, 2013. A video of a February 2013 radio interview about the Office's investigation into services for adults with developmental disabilities in crisis received about 1,200 views.

The Office began advertising employment opportunities on **LinkedIn** in 2012-2013, receiving more than 4,000 views in just a few weeks.

Website and mobile app

The Ombudsman's website (www.ombudsman.on.ca) saw record visitor numbers in 2012-2013. The site, redesigned in June 2011, continues to evolve and now provides more information, embedded video, news articles, social media sharing tools, speeches, and resources.

According to Google Analytics, the website had **100,096** unique visitors in 2012-2013 – a 24% increase over the previous year. The site received **159,795** total visits, and more than **552,800** pageviews. Most visitors are from Canada, the U.S., the U.K. and Australia, but others came to the site from **174** countries.

The mobile-optimized version of the Ombudsman's site, which users can download directly to the homescreen of a smartphone or tablet, was launched in November 2011. There were **14,210** unique visitors and **19,632** total visits to the mobile site in 2012-2013.

> "Well done. Not just for well executed projects but w increasing the # of Ontarians who understand the role of OO and use OO."
>
> @csgreentree, via Twitter

In another first, the Office began live webcasting speeches and events, in addition to press conferences, in 2012-2013. These are available in real time on the front page of our website and then archived on our YouTube channel. Combined with our practice of live-tweeting events, this technology allows anyone interested in the Ombudsman's work to have a front-row seat.

The Office also increased its use of the video-calling service **Skype** in 2012-2013, for speaking engagements, meetings and connecting with complainants and witnesses in investigations.

Outreach

The Ombudsman was invited by numerous groups to be a guest speaker in 2012-2013, as were several members of his team. He addressed several university and college audiences, including at the University of Ottawa and University of Toronto law faculties, Carleton University and Humber College. Ombudsman staff also participated in outreach events at the University of Windsor and University of Ottawa law faculties.

Among many other engagements, he was asked to speak about civilian oversight of police on several occasions, including the 50th annual conference for the Ontario Association of Police Services Boards, a conference organized by the Civil Liberties Association of the National Capital Region and at the annual conference of the U.S.-based National Association for Civilian Oversight of Law Enforcement.

The Ombudsman was also invited to speak about social media as essential tools for ombudsmen at the 10th World Conference of the International Ombudsman Institute in Wellington, New Zealand.

Ombudsman senior staff spoke to a wide variety of groups in 2012-2013, including the Canadian Centre for Ethics and Corporate Policy, the Consumer Specialty Products Association, the Northern Ontario Service Deliverers Association, the Canadian Health Care Anti-fraud Association, the Ontario Federation of Community Mental Health and Addiction Programs, the Canadian Life and Health Insurance Association, and the Tema Conter Memorial Trust.

In addition, because MPPs play an important role in the Ombudsman's work – in referring complainants and issues to our Office – the Ombudsman invited all members of the Legislature to an outreach event in May 2012 at Queen's Park. The event offered MPPs a chance to speak informally with the Ombudsman and staff members about how the Office handles complaints and investigations. The Office also offered to conduct presentations for constituency staff for all parties on how complaints can be referred to us for resolution or investigation.

And the award goes to...

Ombudsman André Marin was honoured with the following awards in 2012-2013, recognizing his contribution to law and public service in Ontario:

JOHN TAIT AWARD OF EXCELLENCE, Canadian Bar Association, August 2012
This national award is presented annually to a public sector lawyer who exemplifies pre-eminent public service, and honoured the Ombudsman's commitment to social justice in Ontario.

COMMON LAW HONOUR SOCIETY, University of Ottawa Faculty of Law, September 2012
The faculty's most prestigious award for graduates in common law, this award (pictured, below left) honoured the Ombudsman's significant contribution to the law profession and to the community.

ACHIEVEMENT IN OVERSIGHT AWARD, National Association for Civilian Oversight of Law Enforcement (U.S.), October 2012
In a rare recognition of achievement outside the U.S., this new award (pictured, below right) honoured the Ombudsman's significant work in exposing the challenges facing Ontario's civilian police oversight agency, the Special Investigations Unit.

Special Ombudsman Response Team

Established in 2005, the **Special Ombudsman Response Team**, or SORT, conducts investigations into high-profile, complex issues, looking for the root causes of issues and solutions to systemic problems.

SORT's approach to investigations incorporates cutting-edge techniques including those used by police in major case management. Normally several investigations are ongoing at once. Each case is meticulously planned to ensure resources are used as efficiently as possible to gather large quantities of evidence. Most interviews are digitally recorded and documentary evidence is carefully reviewed.

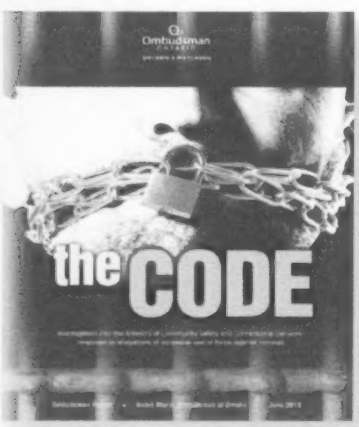
In each case, a lead investigator is responsible for the day-to-day tactical direction of the investigation in the field, assisted as required by other investigators and Ombudsman staff such as legal counsel, Early Resolution Officers and communications staff.

SORT staff also monitor the government's implementation of the Ombudsman's recommendations in the months and years after an investigation is completed. If warranted, investigations can be reopened.

The methods used by SORT form the basis of the Ombudsman's world-renowned training course, "Sharpening Your Teeth: Advanced Investigative Training for Administrative Watchdogs," now in its seventh year. Staff from hundreds of ombudsman offices and investigative agencies around the world have participated in this training – for more information, see the **Training and Consultation** section of this report.

SORT investigations completed in 2012-2013

The Code – Ministry of Community Safety and Correctional Services



In June 2013, the Ombudsman released his report on allegations of excessive use of force against inmates by correctional officers in the province's correctional facilities. The investigation exposed the "code of silence" among some correctional staff that led to serious cases of assault being covered up or improperly investigated. The Ministry acknowledged this grave problem and committed to implementing the Ombudsman's recommendations.

The investigation stemmed from complaint trends that Ombudsman staff had tracked for years – more than **350** complaints about unreasonable force from 2009 to present. In November 2010, the Ombudsman brought several cases to the Ministry's attention where policies were not followed and there was evidence of violence being covered up by correctional staff.

The Ministry initially dismissed the Ombudsman's concerns, although after reviewing the cases and confirming the Ombudsman's assessments, it began its own review to address the issues. But its progress was slow, and in August 2011, the Ombudsman notified the Ministry that he was launching a systemic investigation into its response to allegations of excessive use of force against inmates, including the adequacy and enforcement of policies and investigation of such incidents.

During the release of his report *The Code*, Ombudsman André Marin discusses an inmate who received serious injuries at the hands of a correctional officer, June 11, 2013.

The announcement sparked **147** complaints from inmates, former inmates, and their families and legal representatives, as well as from whistleblowers within the Ministry itself. The investigation team reviewed thousands of documents and conducted 182 interviews across the province, including with inmates and former inmates, correctional officers and managers, nurses and institution administrators. They also interviewed numerous officials at various levels of the Ministry, union officials and other stakeholders.

During the course of the investigation, the Ministry developed and implemented a number of initiatives and policies aimed at addressing many of the issues the Ombudsman raised. It also fired more than 30 staff, disciplined more than 100 and saw five charged with criminal assault.

The Ombudsman made 45 recommendations in the report. The Ministry committed to reporting back to the Ombudsman every six months on its progress in implementing them.

> "[I]t is clear that we must do more to crack the "code of silence" that hampers investigations and intimidates inmates and staff members who come forward."
>
> Deputy Minister of Correctional Services, letter responding to Ombudsman's draft report, May 22, 2013

> "The Ministry has taken some solid initial steps in the right direction, but it will need to follow through.... It must take all reasonable precautions to protect inmates from abuse by those responsible for their protection. This includes ensuring vigorous action is taken to eradicate the code of silence that threatens the security of inmates and staff alike."
>
> Ombudsman André Marin, *The Code*, June 2013

In the Line of Duty – Ontario Provincial Police and Ministry of Community Safety and Correctional Services

In October 2012, the Ombudsman released his report on how the Ontario Provincial Police and the Ministry of Community Safety and Correctional Services were addressing operational stress injuries affecting police officers. Operational stress injuries include conditions such as depression, addictions, anxiety and post-traumatic stress disorder, or PTSD.

The investigation, launched in March 2011, looked into complaints from **111** active and retired OPP and municipal officers and their families. It revealed that a strong stigma and "suck it up" culture persisted against officers with operational stress injuries, along with a serious lack of related support services and training for OPP members.

This extensive investigation comprised **191** interviews with OPP and municipal officers, OPP and Ministry staff, health service providers, psychologists, psychiatrists, traumatic stress specialists and interest groups. Other law enforcement agencies were also contacted, including the Royal Canadian Mounted Police, Toronto, Calgary and Montreal police and the California Highway Patrol. SORT also looked into how all other Canadian provinces handled operational stress injuries among police.

> "[F]or the OPP officers who have long struggled with the effects of PTSD, Ombudsman André Marin's report *In the Line of Duty*... is a long-overdue validation of what they have endured and continue to endure. It is also a blueprint for changing the culture of stigma and shame within the organization."
>
> *Toronto Star* editorial, October 27, 2012

> "Given the massive personal toll on police officers and their families caused by operational stress, to say nothing of the huge costs borne by taxpayers when officers are disabled by PTSD, surely taking long-overdue action on Marin's report is a no-brainer."
>
> *Toronto Sun* editorial, October 27, 2012

> "This report challenges us to do better, and we want to make sure we take better care of our folks."
>
> OPP Acting Superintendent Dave Quigley, Simcoe.com, October 31, 2012

The Ombudsman found that while the OPP had recently made some progress in addressing operational stress injuries, serious gaps remained. The OPP employed only one psychologist for a force of more than 8,000 uniform and civilian workers. While members of some specialty units had access to help and support, most officers had only a basic employee assistance program that did not sufficiently address the traumatic realities of police work and did nothing to help officers find professional help in their communities.

The report also revealed that the OPP had no official statistics on officer suicides – even though more active and retired officers had killed themselves since 1989 (23) than had been killed in the line of duty (21). During the course of the Ombudsman's investigation, five OPP officers took their own lives. Yet the OPP had no suicide prevention program and did not conduct psychological autopsies in suicide cases to help prevent more.

Ombudsman André Marin releases his report, *In the Line of Duty*, October 24, 2012.

The Ombudsman's report made 28 recommendations to the OPP and six to the Ministry. Among other things, he recommended the OPP implement a comprehensive education and training program relating to operational stress injuries; improve its employee assistance programs, psychological services and peer support services; collect data on member operational stress injuries and implement a suicide prevention program. As well, he recommended the Ministry conduct a provincewide survey to identify how many officers are dealing with operational stress injuries, establish statistics on police suicides in Ontario and develop provincial standards for police services to address operational stress injuries.

The OPP's initial response to the report was described by the Ombudsman as "disappointing" and a "bureaucratic brushoff." However, senior OPP officials committed to implementing the recommendations and sent their first quarterly report back to our Office in January 2013. The Ombudsman said on Twitter that this first update was "substantive and gives real hope that [the OPP] is moving in the right direction." Its second quarterly report, received in April 2013, also gave a very positive snapshot of the progress that the OPP is making in implementing the recommendations.

Among the initiatives introduced by the OPP to date are a list of community supports available to officers; specialized training to civilian clinicians about OPP programs; and a review in conjunction with the Ministry and Office of the Chief Coroner to identify police suicides.

The Ministry also committed to work with police stakeholders to develop a survey to assess prevalence of operational stress injuries amongst Ontario police officers; obtain information about programs used by Ontario's police services to address operational stress injuries and suicide; and conduct research to develop provincial standards relating to these issues.

The Ombudsman will continue to receive quarterly updates from the OPP and the Ministry. (More comments from police and their families can be found in the **Your Feedback** section of this report.)

> "My wife was an OPP constable who committed suicide in 2010, and I was fortunate enough to be able to participate in this report. The investigators for the Ombudsman's office were incredibly professional and thorough and kept me in the loop throughout the investigation… There are good people in the OPP that are trying to make changes, but it will be a long time in coming. I pray this report will shine some much-needed light on the subject and speed up the process of change."
>
> Jason MacKenzie

> "Never before have people in this organization spoken so openly about their mental health. This open dialogue is an important step toward reducing the stigma that keeps people from seeking help."
>
> Report from OSI Working Group, "Addressing Operational Stress Injuries" *The OPP Review*, Winter 2012-Spring 2013

> "For too long, police and military cultures have had a 'suck it up' attitude towards psychological trauma and members rightly feared that talking about their difficult experiences might negatively impact their careers. No more."
>
> OPP Commissioner Chris Lewis, *The OPP Review*, Winter 2012-Spring 2013

Dental implants – Ministry of Health and Long-Term Care

In his 2009-2010 Annual Report, the Ombudsman highlighted the case of a cancer sufferer who was refused funding for four dental implants after surgery on his jaw and palate. Three years of co-operative work between Ombudsman and Ministry staff have resulted in a new program for patients in similar situations – all without need for a formal investigation.

The 55-year-old man suffered from squamous cell carcinoma and his treatment, beginning in 2006, had involved extensive surgery to remove cancerous tissue and bone from his face and mouth. He also underwent reconstructive surgeries and skin grafts, followed by chemotherapy and 28 radiation treatments.

By January 2007, he was unable to speak or eat properly because so much bone had been removed from the left side of his face. His physical and psychological condition deteriorated and his doctors determined that he needed a prosthesis and the insertion of four titanium screws (dental implants) into what remained of his jawbone.

He applied for Ontario Health Insurance Plan (OHIP) funding but was turned down on the basis that dental implants are not "insured devices" and are considered "cosmetic." His subsequent appeal to the Health Services Appeal and Review Board was also turned down because, though acknowledged as medically necessary, the implants were not listed in the Schedule of Benefits for Dental Services.

The man complained to the Ombudsman in September 2009 and SORT conducted a preliminary investigation. OHIP officials took the position that dental implants are not insured, as they are generally used in cosmetic dentistry. However, after further discussion with Ombudsman staff, Ministry officials acknowledged the man's case was exceptional, and in October 2009 agreed to fund the implants, which he received in summer 2010.

SORT continued to investigate the potential systemic implications of this issue. Some **22** complainants came forward between January 2009 and March 2013 who similarly needed dental implants for non-cosmetic, medically necessary purposes resulting from catastrophic events such as cancer.

Ombudsman staff remained in contact with Ministry officials, including the Deputy Minister, as a program to help these people was developed. The Ministry launched its new Oral and Maxillofacial Reconstruction Program on April 1, 2013. Under this $5-million annual program, the province will provide funding for implant-retained maxillofacial intraoral prostheses to restore oral function for patients who have no other treatment alternatives.

Ongoing SORT investigations

Adults with developmental disabilities in crisis – Ministry of Community and Social Services

In November 2012, the Ombudsman announced an investigation into whether the Ministry of Community and Social Services is adequately responding to urgent situations involving adults with developmental disabilities, and whether it is doing enough to co-ordinate, monitor and facilitate access to services for them.

The Ombudsman's Office has investigated many individual complaints on this issue over the past two years, a few of which have also been the subject of media reports. The number of complaints has risen steadily – from 35 in 2010, to 45 in 2011, to 64 in 2012 before the investigation was announced. Hundreds of new complaints poured in after the investigation was launched – there were more than 500 as of March 31 and that number climbed to well over **800** by the time this report was finalized for publication.

> "We have heard heart-wrenching stories from aging or ill parents whose adult sons and daughters are a danger to themselves and others and need constant care that can't be provided at home – but they have nowhere to turn.
>
> "Some of these caregivers are on the brink of emotional and physical breakdown. We have investigated past cases where people with these severe disabilities have been sent to shelters and even jail. What is particularly troubling is that our complaints have only gone up, despite new legislation and changes made by the Ministry in recent years."
>
> Ombudsman André Marin, press release launching investigation, November 28, 2012

To date, SORT investigators have conducted more than **190** interviews across the province, including with adults with developmental disabilities, their families, officials from the Ministry of Community and Social Services, Developmental Services Ontario, and other stakeholders. The field work phase of the investigation – interviews and other evidence gathering – is almost complete, although new individual complaints are still being reviewed. The investigation team is assessing the evidence, after which the Ombudsman's report and recommendations will be drafted and the Ministry given a chance to respond.

The Ombudsman expects to report on this investigation later this year.

> "What kind of province forces loving parents to contemplate abandoning their disabled children to child welfare or a homeless shelter just to get them the help they need? Ontario must not be that place."
>
> *Toronto Star* editorial, September 25, 2012

Monitoring of drivers with uncontrolled hypoglycemia – Ministry of Transportation

In March 2012, the Ombudsman announced an investigation into how the Ministry of Transportation monitors drivers who have uncontrolled hypoglycemia and could be a danger on the roads.

In announcing the investigation, the Ombudsman emphasized that although most drivers who have diabetes are perfectly safe, the condition of uncontrolled hypoglycemia is deemed serious enough that Ontario and other provinces require medical professionals to report it to the Ministry.

The investigation was sparked by the 2009 case of a Hamilton driver who caused a crash that killed three people when he was in "diabetic shock." Family members of the accident victims asked the Ombudsman to look into how the Ministry obtains information about drivers with uncontrolled hypoglycemia and takes action when warranted. In the Hamilton incident, the driver's condition was reported by police and a physician to the Ministry, but it did not suspend his licence until 2011.

It has been mandatory since 1968 for Ontario physicians to report patients who suffer from a medical condition that may make it unsafe for them to drive. Police can also report drivers they suspect are unfit, based on complaints or witnessed behaviour. In cases where uncontrolled hypoglycemia is reported, the Ministry can issue an immediate suspension of the driver's licence.

This investigation is now complete and the Ombudsman is in the process of drafting his report. SORT investigators conducted more than **60** interviews, including with Ministry staff, interest groups such as the Canadian Diabetes Association, experts in the field and other stakeholders. They also gathered thousands of pages of documentation and reviewed national standards and best practices from other jurisdictions.

The Ombudsman expects to report on this case later this year.

Completed SORT assessments in 2012-2013

Slots at Racetracks program – Ontario Lottery and Gaming Corporation

The Ombudsman received more than **350** complaints in the spring of 2012 in the wake of the government's decision to end its Slots at Racetracks program, largely from stakeholders in the horse racing industry. Because of the high volume of complaints and the serious concerns raised, a team of investigators was assigned to interview dozens of horse owners, trainers and others whose livelihoods were affected by the change. They also interviewed senior officials with the Ontario Lottery and Gaming Corporation and the relevant ministry, then known as the Ministry of Agriculture, Food and Rural Affairs.

After an extensive review of the evidence gathered, the Ombudsman determined that the government's decision was a matter of broad public policy, and decided not to launch a formal investigation. In a publicly released letter to complainants explaining this decision in March 2013, he noted that it is not the Ombudsman's role to substitute his views for the judgment of elected representatives, but to focus on issues relating to government administration.

The government has since negotiated to retain slots at some racetracks.

Updates on previous SORT investigations

Non-emergency medical transportation services – Ministry of Health and Long-Term Care, Ministry of Transportation

In 2011, the Ombudsman completed an investigation into whether the Ministry of Transportation and the Ministry of Health and Long-Term Care were adequately protecting the public who use non-emergency medical transportation.

Non-emergency transportation services are private companies that transfer hundreds of thousands of patients each year whose condition is deemed "non-critical" and not requiring ambulance service. Most transfers are between medical facilities, long-term care homes and/or patients' residences. The vehicles resemble ambulances, but are not – and the industry is not regulated.

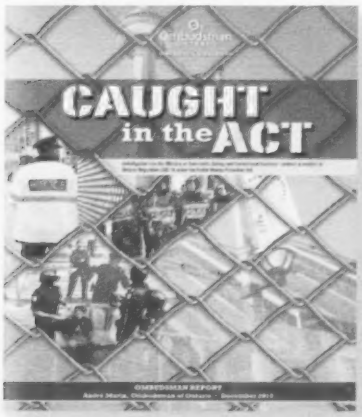
The investigation found significant problems, including poorly trained staff, inadequate equipment and lack of infection control. The Ombudsman shared a working draft of his findings with the two ministries in May 2011. In June 2011, the then ministers of Transportation and Health and Long-Term Care jointly announced that legislation would be introduced to regulate the industry.

Unfortunately, there has been considerable delay in introducing legislation, in part due to the calling of a provincial election just prior to the ministers' announcement in June 2011, and the prorogation of the subsequent session of the Legislature in 2012.

The Ombudsman pursued this issue with the Ministry of Health and Long-Term Care, which was to lead the process of regulating the industry. The Ministry began consultations with stakeholders, with a commitment from the Minister that regulation would follow. In late 2012, the Minister received a report and recommendations arising from consultation. That report remains under review by the Minister. SORT continues to monitor this issue and pursues regular updates from the Ministry. The Ombudsman also discussed it with the present Minister of Transportation in May 2013.

> "Our government is taking steps to ensure the safety of passengers being transferred in non-emergency situations. We know this action will make a difference for the patients who rely on these services. I would like to thank the Ombudsman for his crucial input into this important issue." – Deb Matthews, Minister of Health and Long-Term Care
>
> "Our government is committed to the safety of all drivers and passengers, including passengers being transferred during non-emergency situations." – Kathleen Wynne, Minister of Transportation
>
> "Ontario Strengthening Patient Safety: McGuinty Government to Regulate Non-Emergency Medical Transfer Services," government press release, June 10, 2011

Caught in the Act – Expansion of police powers for Toronto G20 summit – Ministry of Community Safety and Correctional Services



The Ombudsman's December 2010 report, *Caught in the Act*, revealed the Ministry of Community Safety and Correctional Services' role in quietly granting police additional powers during the G20 summit held in Toronto in June 2010.

The report highlighted the confusion amongst security personnel and civilians when police used their powers thanks to a new regulation under the virtually-unknown *Public Works Protection Act (PWPA)* of 1939, which allowed them to search and detain hundreds of protesters and mere bystanders.

In his report, the Ombudsman concluded that the Ministry-sponsored regulation under the *PWPA* had essentially suspended normal civil rights, resulting in more than 1,000 people being searched and/or detained by security forces. He recommended, among other things, that the *PWPA* be repealed or replaced to ensure this could not happen again.

The Ministry agreed with this recommendation and introduced legislation to replace the *PWPA* in February 2012. That bill (Bill 34) limited the extraordinary security measures found in the *PWPA* to courts, power stations and nuclear facilities. It was referred for third reading but was not proclaimed, and hence died when the Legislature was prorogued in October 2012.

In April 2013, the government introduced Bill 51, the *Security for Courts, Electricity Generating Facilities and Nuclear Facilities Act*, which has similar provisions to the previous bill. It went to second reading on April 24, 2013.

Monitoring of long-term care homes – Ministry of Health and Long-Term Care

In December 2010, the Ombudsman released his findings on the Ministry of Health and Long-Term Care's compliance monitoring of long-term care homes, a SORT investigation launched in July 2008. At that time, the Ombudsman noted that the Ministry's efforts were "a work in progress," thanks to the proclamation of new legislation and an ongoing Ministry project to transform the compliance system. The Ombudsman and SORT have closely monitored the Ministry's efforts in this area ever since.

The Ombudsman has no jurisdiction over long-term care homes themselves, a mixture of for-profit private, charitable and municipal homes (we received **70** complaints about long-term care homes this year; for more on this, see the section of this report entitled **Beyond Scrutiny – MUSH sector update**). His investigation focused on the effectiveness of the Ministry's monitoring of the homes and whether its standards were realistic or detracting from effective compliance monitoring and patient care.

The investigation revealed four areas of concern: Inconsistent application of the standards used to monitor long-term care homes; delayed inspections; a lack of rigour in investigating complaints; and inadequate public reporting of compliance inspection findings.

The Ministry has provided progress updates to the Ombudsman on a semi-annual basis since 2010, and the Ombudsman continues to monitor complaints from the long-term care sector and remains in contact with related stakeholders.

In his December 18, 2012 progress update letter, the Deputy Minister said the Ministry had addressed all of the Ombudsman's recommendations and cited such accomplishments as:

- Full implementation of the redesigned Long-Term Care Homes Quality Inspection Program, which guides the enforcement of standards set out in the *Long-Term Care Homes Act, 2007,* and Ontario Regulation 79/10, which came into force on July 1, 2010; and
- the introduction of the Centralized Intake, Assessment and Triage Team in the fall of 2012. This team receives, assesses and triages complaints about long-term care homes and all critical incidents they report.

The Deputy Minister also acknowledged the role of the Ombudsman's Office in improving oversight of long-term care homes:

> "I would like to thank you for your recommendations, guidance and support of the improvements that have been made in the [long-term care] home sector. As a result, I believe that we have a greatly improved program in place today that helps to ensure residents in Ontario's [long-term care] homes are safe, and are receiving high quality care....
>
> "I am also very pleased that over the past three years, our organizations worked collaboratively, transparently shared information, and developed strong, productive relationships. This was instrumental in being able to implement all of the recommendations."

Notwithstanding the progress that has been made, the Ombudsman continues to receive serious complaints about how the Ministry monitors the long-term care system. In the past fiscal year, we received 35 complaints about the Ministry's Performance Improvement and Compliance Branch. They include concerns about the quality of investigations, delayed inspections and reports, and a lack of follow-up by the Ministry in cases of non-compliance. SORT is assessing these complaints and the Ombudsman is considering what action should be taken, including whether or not to launch a follow-up investigation.

Oversight Undermined and *Oversight Unseen* – Ministry of the Attorney General and Special Investigations Unit

The Ombudsman has done two investigations and issued two reports related to the Special Investigations Unit – the agency that conducts independent investigations when police are involved in incidents of serious injury or death. The first, *Oversight Unseen* (2008), focused on the SIU's operational effectiveness and credibility; the second, *Oversight Undermined* (2011), looked into the Ministry of the Attorney General's response to the first report.

In both reports, the Ombudsman called on the Ministry and government to support the work of the SIU through clearer, stronger legislation outlining the SIU's mandate and police obligations to co-operate with it.

The Ombudsman revealed in *Oversight Undermined* that rather than supporting the SIU in holding police to account, the Ministry was, in some respects, actively undermining it. He pointed to an internal Ministry email that noted his recommendations calling for stronger legislation supporting the SIU were not acted upon "largely due to vehement police opposition."

> "This is not a criticism, but a fact of life: The police lobby is very powerful – in fact, I can't think of another interest group in society that is more powerful. Police put their lives on the line to stop crime and protect our communities. They are heroes to many of us. And … they have guns."
>
> "What's Wrong – and Right – With Ontario's Police Oversight," Speech by Ombudsman André Marin, Carleton University "Policing the Public" symposium, Ottawa, March 9, 2013

Since the release of *Oversight Undermined*, the Ombudsman has received regular updates from the SIU on apparent ongoing problems with co-operation by police services – in particular, failure or delay by police services in notifying the SIU of incidents within its mandate; and witness officers refusing to answer questions about whether they consulted with a lawyer before writing their notes.

As well, while some police services – such as the Ontario Provincial Police and Windsor and Brantford local police – have shown a marked increase in responding to letters from the SIU Director about problems, others continued to ignore them. For example, the SIU wrote 19 letters to the Toronto Police Service in 2012, raising concerns about various failures to co-operate with the SIU during investigations. It received no written response.

For its part, the Ministry has yet to respond substantively to the Ombudsman's recommendations. In December 2012, the Ombudsman wrote to the Attorney General to request a report on what steps the Ministry plans to take to reinforce the integrity of the SIU's investigative process. The Attorney General committed to a review of SIU/police-related issues commencing in 2013. The Ombudsman requested detailed quarterly updates on the progress of this review.

Meanwhile, some of the key issues raised in the Ombudsman's reports have figured prominently in recent court cases.

The failure of Toronto Police to notify the SIU was raised in a provincial court case in March 2013, in which a judge found a Toronto Police officer used excessive force in arresting 30-year-old Toronto chef Raymond Costain. Provincial court Justice Ford Clements said two officers seemed "indifferent to the truth" and had attempted to cover up Costain's injuries by turning off the cameras in their cars; the SIU was also not notified of the incident.

And in April 2013, the Supreme Court of Canada heard an appeal of an Ontario Court of Appeal case dealing with the issue of police association lawyers vetting officers' notes before submitting them to the SIU. The Ontario court ruled in 2011 that officers cannot have a lawyer vet their notes. The case stems from two fatal shootings of civilians by Ontario Provincial Police officers, whose families are seeking a court declaration that vetting of police notes is improper. In *Oversight Unseen*, the Ombudsman also recommended that this practice not be allowed. The Supreme Court's decision is pending.

Another recommendation from *Oversight Unseen* was echoed by the Law Society of Upper Canada in November 2012, when it issued an advisory under the Rules of Professional Conduct to lawyers representing police officers, prohibiting them from representing multiple officers in SIU investigations.

In a March 2013 speech to a symposium at Carleton University on police oversight, the Ombudsman reiterated his call for new legislation to bolster the SIU. He said the legislation should:

- Clearly define what kind of "serious injury" should trigger the SIU's mandate;
- Allow the SIU to investigate police obstruction of its mandate and lay charges when it happens; and
- Prohibit police lawyers representing multiple officers and interfering with notes.

The Ombudsman also called on police services boards to hold police chiefs accountable by making their duty to co-operate with the SIU a performance objective in their contracts.

The Ombudsman will continue to monitor issues relating to the SIU.

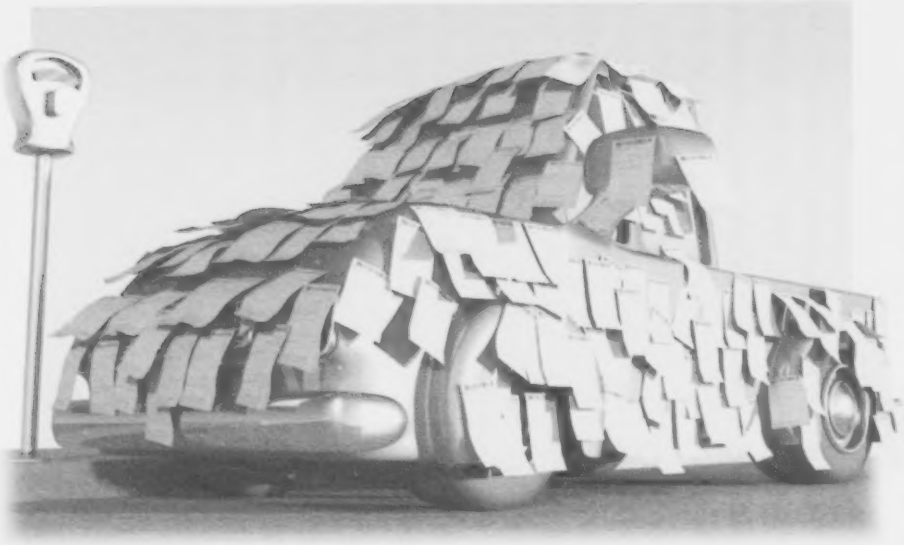
Between a Rock and a Hard Place – Care and custody of children with severe special needs – Ministry of Children and Youth Services

In his 2005 report, *Between a Rock and a Hard Place*, the Ombudsman revealed the disturbing problem of parents of children with severe special needs being forced to surrender their custody to children's aid societies (CASs) in order to obtain the care they needed. At that time, and several times since, the government committed to ensuring this would no longer happen. Nevertheless, parents continue to complain that they have been pushed to make this heart-wrenching choice. There were two such cases in 2012-2013.

In the first case, a CAS case worker told the father of an 11-year-old boy with a rare genetic disorder, autism and serious behaviour problems that he would have to put the boy in CAS custody so funding could be accessed for placement in a residential treatment program. The boy, who functioned at the level of a six-year-old, had been hospitalized after setting fires three times. The father, a single parent, said the CAS case worker had directed him to the Ombudsman's Office for help. Ombudsman staff flagged the case to Ministry of Children and Youth Services officials. They provided direction to the local service co-ordination agency and funding and a placement in a group home was arranged for the boy.

In the second case, a worker at the local service co-ordination agency told the mother of a nine-year-old boy her only option was to sign a temporary care agreement with the local CAS so they could access funds to place him in a group home or give her weekend respite. The mother did not want him to go to a group home, but without support services, he had become aggressive and unmanageable at home. Ombudsman staff confirmed that there were no child protection concerns in this case and spoke to the agency about the message it was giving to parents. Soon after, services were arranged for the family, including respite for the mother, family therapy and a placement for the boy in a special classroom.

Ombudsman staff continue to monitor this issue closely. Similar complaints are brought directly to the attention of senior Ministry officials.



MINISTRY OF THE ATTORNEY GENERAL

Public Guardian and Trustee

No Parking

A hospital social worker contacted the Ombudsman on behalf of a client of the Office of the Public Guardian and Trustee (OPGT) who was a long-term resident of a psychiatric hospital. The man's car had been left in the hospital parking lot for eight months and had received 13 parking tickets. The OPGT, which was responsible for handling the man's financial affairs, did nothing with the car even though it had the man's agreement to remove and sell it. The tickets were sent to the OPGT, but it did nothing about them.

It wasn't until the hospital threatened to tow the car away that it was removed by the OPGT and sold. The OPGT's area manager spoke to Ombudsman staff and acknowledged the lack of response by the man's assigned representative. The OPGT also agreed to pay the parking tickets at no cost to the man or his credit rating.

Discreditable conduct

A client of the OPGT complained to the Ombudsman about a ruling by a capacity assessor that he was incapable of managing his own financial affairs – a ruling that made the OPGT guardian of the man's property. The man argued that the assessor had judged him incapable because he refused to acknowledge that he had a debt of about $8,000.

When Ombudsman staff spoke to the OPGT, it was revealed that the capacity assessor had been given the wrong information by the OPGT – the man had no such debt, but rather an unused credit line for $8,000. The OPGT agreed to pay for a new capacity assessment, which found the man was able to manage his own finances.

Case summaries

Consent and Capacity Board

The form so nice, they named it twice

A 76-year-old woman complained to the Ombudsman that despite a ruling of the Consent and Capacity Board (CCB) that found her capable of managing her own affairs, the Office of the Public Guardian and Trustee was still involved with her finances.

Ombudsman staff determined that the woman had used the wrong form in her dealings with the CCB. It turned out there were two different forms called "Form 18" on the CCB's website, for requesting a review of a finding of incapacity to manage financial affairs. One form was to request a review of findings under the *Mental Health Act*; the other for findings under the *Substitute Decisions Act*.

The patient advocate who assisted the woman used the *Mental Health Act* Form 18 because she was a patient in a psychiatric facility at that time. But the CCB's finding did not terminate the jurisdiction of the OPGT because it was made under the *Substitute Decisions Act*. And in that case, the assessor who made the original finding of incapacity would have to appear at a hearing before the OPGT's involvement in the woman's affairs could be terminated.

In the wake of the Ombudsman's inquiries, the CCB agreed to change the information on its website to clarify the differences between the two versions of "Form 18."

Ministry of Community Safety and Correctional Services

Working for the weekend

An inmate who has a psychiatric illness complained to the Ombudsman that he had not received essential medication over the weekend because there was no nurse on duty at the jail. His condition deteriorated, leaving him with his mind racing and feeling like he was "flipping out." He said he did not want to be in a similar situation the following weekend.

The health care manager at the jail confirmed that nursing staff had neglected to prepare the inmate's medication before leaving for the weekend. Senior management at the jail reviewed the incident and reminded those responsible that the dispensing nurse should be contacted at home if an inmate reports missing medication on weekends. The nurse is to assess the situation and go to the jail if warranted to ensure all inmates have their essential medication.

A neighbour in crisis

An inmate in a detention centre called the Ombudsman out of concern for a 19-year-old female inmate who had been cutting herself and was on "suicide watch." He said she had been taken off her anti-depressant and anti-psychotic medications and was taken to a segregated cell in handcuffs.

Staff at the institution confirmed that the woman had a history of mental illness and cutting herself and had recently been transferred from the young offender system. She was scheduled to be released in four days, and inquiries by Ombudsman staff revealed that she was to be dropped off at a shelter with no treatment or medical support. After Ombudsman staff raised concerns about the woman's welfare to the detention centre superintendent, she was evaluated by the institution's psychiatrist, who arranged to have her taken to hospital for further psychiatric evaluation upon her release.

Case Summaries

Is there a doctor...?

An inmate complained to the Ombudsman that he was not receiving adequate psychiatric treatment. He had submitted several written requests to be seen by a psychiatrist, a social worker and an addictions counsellor, to no avail. He told Ombudsman staff he was very distressed and would commit suicide if he did not receive treatment.

After Ombudsman staff relayed the inmate's concerns to the health care manager at the institution, he was immediately assessed by a psychiatrist and prescribed anti-anxiety medication. A social worker and an addictions counsellor also met with him. The inmate later reported to Ombudsman staff that he found the treatment helpful and was feeling better.

An overflow of problems

A correctional officer at a large correctional centre alerted the Ombudsman to poor living and working conditions in an "overflow" unit, used to house inmates who could not be housed in the general population. Due to a shortage of staff, inmates were not getting access to showers, the yard or phones, and garbage was piling up.

After the Ombudsman's Office contacted the institution's deputy superintendent, management brought in more staff to ensure inmates had access to showers, the yard and phones, and a plan was made to move the "overflow" inmates out the following week. However, a later follow-up revealed more inmates had been placed in the unit. The deputy superintendent again intervened to ensure the unit would only be used to house inmates serving weekend sentences.

Chief Firearms Officer

Right to Appeal

A gun owner complained to the Ombudsman that the Chief Firearms Officer (CFO) had revoked his authorization to transport a firearm without providing him with a formal notice as required under the *Firearms Act*. Without the notice, he was unable to challenge the decision in court.

Ombudsman staff determined that the man's authorization was revoked because he failed to meet the condition that he maintain his gun club membership. CFO officials argued that this constituted a "request" by the man for revocation of his authorization and no notice from them was required.

Senior Ombudsman staff met with the Chief Firearms Officer, who ultimately agreed that a formal notice should have been issued so the man could exercise his right to appeal the revocation in court. It was also agreed that notices of revocation should always be issued in cases where the holder of an authorization fails to meet conditions of the authorization.

MINISTRY OF COMMUNITY AND SOCIAL SERVICES

Services for adults with developmental disabilities

Working together

The mother of a 20-year-old man who has complex developmental and medical needs – he has Down Syndrome, uses a ventilator and has other complex medical conditions – turned to the Ombudsman after she was unable to find a permanent residential placement for her son.

While living with his family, the young man received 53 hours per week of nursing care through his local Community Care Access Centre (CCAC), but he needed a permanent group home placement. He was still receiving funding for his developmental needs through the Ministry of Children and Youth Services as he "transitioned" to services for adults (under the Ministry of Community and Social Services), but the latter ministry was not able to pay for the same level of care and there was no appropriate residential placement available for him.

Ombudsman staff spoke with management at the Ministry of Children and Youth Services, the Ministry of Community and Social Services, the Ministry of Health and Long-term Care, the Local Health and Integration Network (LHIN) as well as the CCAC. As a result, the three Ministries and LHIN developed a "cluster care" model to accommodate this man and six other people in similar situations - all have developmental disabilities and complex medical needs and are between the ages of 18 and 35. The new residence, part of the campus of a non-profit organization that provides services to people with developmental disabilities, opened April 29, 2013.

Family Responsibility Office

Your cheque's in the mail

A mother who was expecting a child support payment of $5,000 contacted the Ombudsman when she could not get an answer from the Family Responsibility Office (FRO) about the whereabouts of the cheque. Her former spouse – a doctor whose income from the Ontario Health Insurance Program (OHIP) was being garnished to pay the child support – confirmed that the money had gone out a week earlier. When she first called the FRO, she was told no payment had been received. Then she was told her cheque had been "damaged." She was very concerned, as she had been counting on the money.

After Ombudsman staff spoke with FRO officials, it turned out the woman was not alone. Her payment was part of a larger package of support payments, all garnished via OHIP, that had been damaged in the mail. The outside label had become illegible from water damage and it was returned to OHIP, where it sat until FRO officials asked for it to be resent.

Ombudsman staff let the mother know her payment would arrive soon. In less than a week, she received two months' payments.

Case Summaries

Correcting the record

A father complained to the Ombudsman that the FRO had wrongly reported him to a consumer reporting agency (a credit bureau) over $10,825.92 in arrears. The man noted that his son had been living with him for just over a year and he was no longer required to pay support to the boy's mother.

Ombudsman staff confirmed there was a temporary court order stating there should be no accrual of child support from the time the boy began living with his father, but the order had not been issued for several months, which left the FRO records out of date.

FRO staff agreed to adjust the amount that the father owed and notify the credit bureau. The father paid the balance owing of $5,250 and noted to Ombudsman staff that once they became involved in his case, FRO representatives who dealt with him were very helpful.

Paid in full

A mother who was owed a significant amount of back child support complained to the Ombudsman that FRO officials were refusing to exercise their option to have her ex-husband jailed for failing to pay, as provided for in a judge's order.

After Ombudsman staff inquired about the case, FRO staff stepped up their enforcement efforts including obtaining a lien on the man's home, garnishing his bank account and suspending his driver's licence. The man soon paid off his child support arrears in a lump sum of $12,075.75.

To his credit

A man complained to the Ombudsman that the FRO had wrongly garnished half his wages and left him with a bad credit rating. His lawyer had even written to the FRO, advising that it had misread the terms of his 2010 court order, but it changed nothing.

Ombudsman staff reviewed the court order. It said the man initially owed $16,593 in support but he had paid $12,692. FRO officials wrongly continued to say he owed the full amount, when he only owed $3,871.

In recognition of its mistakes, FRO staff deleted the man's poor credit report and adjusted his account. He paid the balance owing.

Ontario Disability Support Program

An error in your favour

A man who was owed money by the Ontario Disability Support Program (ODSP) dating back to December 2010 complained to the Ombudsman in August 2012 that he had been shortchanged. He calculated that he was owed $8,968 but had received only $1,140.

Ombudsman staff contacted ODSP staff, who discovered that there had been a computer error in the man's case. They immediately arranged for him to be sent a cheque for the rest of the money. He passed on "a great big thank you" to Ombudsman staff.

No answer

The father of a 40-year-old severely disabled woman applied for ODSP benefits on her behalf when she gained landed immigrant status in October 2011. He complained to the Ombudsman after he heard nothing for three months – no answer to a dozen phone calls, eight voice messages, an in-person inquiry, and several written inquiries.

Once Ombudsman staff spoke with the man's local ODSP office, a verification interview was immediately arranged. The daughter's application was sent on to the Disability Adjudication Unit and she was approved in February 2012 to receive $814 a month.

The Ombudsman's inquiries revealed that the local office had not been following ODSP rules requiring applications to be processed within three weeks. The office developed a tracking system for new applications to avoid delays – a system that proved so successful, ODSP adopted it for use across the province in February 2013.

Case summaries

Going retro

A man complained to the Ombudsman in October 2012 about a dispute with the ODSP over when his eligibility for benefits should begin. He had notified his local ODSP office in September 2010 that he qualified for benefits, but his application went nowhere despite inquiries from his lawyer.

After Ombudsman staff inquired about the status of the man's application, the ODSP granted him **$10,000** in retroactive disability benefits back to May 2011. In response to additional inquiries from Ombudsman staff about this eligibility date, the ODSP reviewed the file again and agreed to make it March 2011 – meaning the man received another $709 in benefits.

The ODSP also provided him with a written decision, allowing him to request an internal review and appeal to the Social Benefits Tribunal if he still disagreed with the eligibility date.

Right from the start

An ODSP recipient complained to the Ombudsman about a dispute over her application for a special diet allowance – which can be recommended by a recipient's doctor. She had asked to apply for the allowance when she first applied for support in November 2009, but ODSP staff would not give her a form. She was told she could not apply for a special diet allowance until her ODSP application was approved – which was 10 months later (July 2010). Her doctor then completed the form, noting that she had six longstanding medical conditions that required a special diet, including celiac disease and multiple food allergies, and she was granted the special diet allowance with an effective date of January 2011 – when the form was completed.

The woman argued that her special diet allowance payments should have commenced in July 2010, when she was deemed eligible for ODSP benefits. The Social Benefits Tribunal denied her appeal because ODSP policy stated that special diet allowance payments begin the date the form is completed.

Ombudsman staff asked ODSP to review the woman's case, noting that her need for a special diet dated back to when she was deemed eligible for ODSP. Upon further review, ODSP staff agreed the woman should have been given the diet form when she first applied for benefits. She received a retroactive payment of the allowance of $1,298.39, dating back to July 2010.

ODSP also updated its procedures to ensure all offices provide applicants with the forms for such allowances upon request when they first apply for support.

A 14-year wait

A woman complained to the Ombudsman about a dispute with the ODSP Overpayment Recovery Unit that dated back to 1998. She explained that back then she was ordered by a court to repay $1,150 because she had collected other benefits at the same time as ODSP. She had paid the debt and had receipts to prove it, but ODSP was insisting she owed $8,000 and had even garnished her recent federal income tax refund of $1,058.

Ombudsman staff spoke to officials at the Overpayment Recovery Unit, who agreed to review the woman's file. When they were unable to find confirmation of the amount owed, they agreed to cancel the debt and refund the amount that had been taken from her tax refund.

Case summaries

Lost in the shuffle

The mother of a developmentally disabled boy applied for ODSP benefits on his behalf in January 2012, four months before he was to turn 18 and become eligible for them. ODSP staff advised parents at an information seminar at the boy's school to apply early because of the lengthy application process. The mother submitted a "pre-application" form at her local ODSP office. She noticed the office date-stamped the form, but she was not given a receipt or copy.

Three months later, she called ODSP to follow up on the status of the application and was told to give them more time. She called again in May and was referred to the Disability Adjudication Unit – which in turn told her it did not have her file. When the ODSP office again checked its computer system, it found no record of her application. She submitted a new application and her son was granted benefits in August, four months after he turned 18.

The mother complained to the Ombudsman when her request for benefits retroactive to her son's birthday in April was denied. Ombudsman staff spoke to ODSP officials about their policy on distributing and processing "pre-application" forms. They agreed to grant the son benefits retroactive to April. As well, they agreed that pre-application forms should be tracked and assigned to case workers to ensure they are properly entered into their system.

A failure to communicate

A man who lost his appeal to the Social Benefits Tribunal about a 2010 ODSP overpayment assessment was advised to complain to the Ombudsman by a member of the tribunal itself. The tribunal had no discretion to waive the overpayment assessment, but the member felt the Ombudsman might be able to help the man with what appeared to be errors and poor communication on ODSP's part.

ODSP wanted the man to repay **$37,206.46** in benefits he received from 2006-2009, even though the man demonstrated that he had provided ODSP with correct information about his situation throughout that time. Ombudsman staff contacted senior Ministry officials about the case. Their review found that the overpayment had accrued solely because of poor communication among the staff dealing with the man's case. They noted that ODSP had since changed its work assignments to ensure an individual case worker was responsible for each case instead of a team, minimizing the risk of communication errors.

The Ministry ultimately agreed the man would not have to repay the money and wrote the debt off as uncollectible.

MINISTRY OF ENERGY

Hydro One

That smarts

After a Hydro One customer's new "smart meter" was installed in October 2011, she noticed her hydro bills were unusually high. She wondered whether she was still being billed based on the old meter's readings. She unsuccessfully tried to resolve the issue with Hydro One by calling them a dozen times, with no luck. In February 2012, worried about her service being disconnected or having to pay interest, she paid her suspiciously high hydro bill and contacted the Ombudsman.

In response to Ombudsman staff inquiries, Hydro One discovered that a problem did occur when the old meter was switched to the new, and they acknowledged that the woman was overbilled by **$1,794.32**, which they credited to her account.

Commercial-free

A woman complained to the Ombudsman that Hydro One had charged her commercial rates on a residential property. She had owned the property since August 2009, but the discrepancy only came to light when a tenant in a building on the property set up his own Hydro account in June 2012.

The woman immediately contacted Hydro One to confirm that her property was wrongly classified as commercial and that she should be charged at the lower residential rate. She was unable to get Hydro One to update her account.

In response to inquiries from Ombudsman staff, Hydro One staff reviewed her file, agreed to change her account to residential – and refunded her the **$494.04** she had been overcharged.

MINISTRY OF FINANCE

Municipal Property Assessment Corporation

Death and taxes

The owner of a funeral home and crematorium complained to the Ombudsman that the Municipal Property Assessment Corporation (MPAC) had unfairly assessed his property. Although it had previously exempted it from property taxes entirely, in 2010 it assessed only the cemetery as exempt and required him to pay taxes on the crematorium for 2008-2012.

The owner noted that other crematoriums in the province had not been required to pay property tax for this period. In fact, new legislation in 2012 recognized that MPAC had historically been inconsistent in its assessment of crematoriums. It provided that those established prior to 2002 would be exempt from property taxes, and refunds would be issued to anyone who paid such taxes in 2010-2012.

The man received a refund for 2010-12 but argued he should be refunded for 2008-2009 as well. As a result of inquiries from Ombudsman staff, MPAC officials agreed to reimburse him for the property taxes he paid in those years due to their assessment.

Case Summaries

Wet and wild

A woman complained to the Ombudsman after requesting a reduction in her property assessment from MPAC and the Assessment Review Board (ARB). She argued that she was unable to use a large portion of her land because it had been zoned as protected wetland by the local conservation authority. MPAC had offered to reduce her assessment by 10%, which the ARB changed to 21%. This reduced the assessed value of her property to $350,000 from $443,000, but she felt it was still not low enough.

Ombudsman staff contacted the Land Program Administrator at the Ministry of Natural Resources to discuss whether its Conservation Land Tax Incentive Program was available for the woman. The program provides tax exemptions for wetlands that are assessed as significant to the province through its Wetland Evaluation System. The program administrator confirmed that the land in question might fall into a category called "low and wet," which would result in a reduction of taxes.

The woman's land was evaluated under the Wetland Evaluation System and deemed "low and wet." As a result, MPAC reconsidered its evaluation of her property and applied a further 9% reduction to be factored into her next property valuation.

Increase in confusion

Owners of two different properties complained to the Ombudsman about confusion over how and when to appeal property assessment change notices issued by MPAC. These notices address changes to a property that affect its value, such as renovations or additions.

In both cases, the owners received these notices in the fall, around the same time they received their regular MPAC assessment notices for the following taxation year. Confusion arose because MPAC's deadline to file a request for reconsideration of an assessment change notice is 90 days from the date of the notice, while the deadline to have regular property assessments reconsidered is March 31 of the following year. MPAC also requires owners to file separate requests for each reconsideration.

One complainant had submitted a single request for reconsideration of both notices. She said MPAC's customer service staff had not told her otherwise, and as a result she was unable to appeal the values in the assessment change notice. The second complainant was in a similar situation because he mistakenly believed the March 31 deadline applied to both notices.

Although both were given information on how to appeal their assessments to the Assessment Review Board, Ombudsman staff brought the cases to the attention of senior MPAC officials so they could avert future complaints.

As a result, MPAC updated its website to direct property owners to an explanation page and frequently asked questions about newly built homes, additions and renovations, and to make the application deadlines more visible on the notices. Ombudsman staff will continue to discuss improvements with MPAC to make information on revised assessment values more accessible.

MINISTRY OF GOVERNMENT SERVICES

Office of the Registrar General

A father's ordeal

The father of a two-month-old baby girl contacted the Ombudsman out of frustration after trying to obtain a birth certificate for his daughter from the Office of the Registrar General. His wife had died of a stroke nine days after giving birth.

The bereaved man wanted to take the baby to visit relatives outside of Canada, but the Office of the Registrar General (ORG) would not issue a birth certificate because the mother had not completed the required application before she died. He had provided them with her death certificate and a report from the coroner's office but this was not enough. The ORG still wanted him to prove he was the baby's father by obtaining an affidavit to that effect from his deceased wife's parents. The man explained that his in-laws lived in a remote rural village in Asia, did not speak or write English, and he was unable to communicate with them.

Ombudsman staff contacted a senior ORG manager, who agreed to accept the couple's marriage certificate from Asia (which included a picture of the couple), as well as documents confirming the deceased mother was a permanent Canadian resident and married to the father. Once the ORG received these documents and the mailing address of the in-laws, it issued the man a birth certificate for his baby daughter.

Past deadline

A mother complained to the Ombudsman that she was having trouble getting birth certificates for three of her four children because they had not been registered within a year of their birth. One daughter, age 4, had cognitive and physical disabilities, but the mother could not obtain benefits for her without a birth certificate.

The ORG told the mother she would have to pay a fee for late registration of the three births, which would require legally sworn affidavits. She estimated this would cost her at least $300 that she could not afford.

Ombudsman staff contacted senior managers at the ORG, who reviewed the woman's file and found that her youngest child's birth had in fact been registered within one year, meaning she could obtain his certificate via a simple online application. They also arranged for ServiceOntario staff to process her applications for the other two children, without her incurring any additional expenses or fees.

MINISTRY OF HEALTH AND LONG-TERM CARE

Community Care Access Centre

Costly convalescence

A woman complained to the Ombudsman about a bill she received for convalescent care after being released from hospital. Her local Community Care Access Centre (CCAC) had arranged to have her spend several months at a seniors' housing residence that offers recuperative programs – which then sent her a bill for **$1,564** that she could not pay.

The CCAC responded to Ombudsman staff inquiries that under its policies, and regulations in the *Nursing Homes Act*, 90 days of convalescent care is provided free of charge. However, the woman was billed for two additional weeks at the residence when her stay there was extended.

Inquiries by Ombudsman staff revealed that the woman's stay was extended because she had been evicted from her own place of residence and had nowhere to go. The CCAC acknowledged that it and the seniors' residence should have flagged this situation and helped the woman's family identify other options. They agreed jointly to cover the bill on compassionate grounds.

Trillium Drug Program

Income outrage

A woman with complex health problems complained to the Ombudsman in September 2012 that the Trillium Drug Program had cut off coverage of her prescription medications, which cost her about $5,000 per year.

Trillium had assessed her deductible at more than $10,000, based on federal income tax information from the Canada Revenue Agency that reflected a one-time pension payout she received when she left her full-time job in 2011. In fact, her living expenses and prescription drug costs exceeded her annual income from a part-time job. She had written to Trillium to explain this situation but heard nothing for two months.

Ombudsman staff spoke with senior staff at the Ministry of Health and Long-Term Care and explained that the woman's 2011 income had been inflated by the pension payout. Ministry staff agreed to reassess her deductible so that her prescription drug costs could be fully covered. That same day, Trillium staff called the woman and clearly explained to her the documentation needed to reassess her deductible. This was done within two weeks.

The woman told Ombudsman staff: **"Without your help, I do not think that things would have been resolved so quickly."**

Ontario Health Insurance Plan

20-20 hindsight

A 72-year-old man who had been treated for a rare form of melanoma in one eye was recommended for a specialized form of radiation therapy in the U.S. after cancer spread to his liver. His oncologist had had other patients successfully treated at the same U.S. hospital, funded through the Ontario Health Insurance Program (OHIP) Out-of-Country program.

The man complained to the Ombudsman after officials at the Ministry of Health and Long-Term Care declined his out-of-country application in July 2012. They advised Ombudsman staff that the treatment was experimental and had not been funded for other patients. The man started chemotherapy in Ontario, but his cancer progressed.

Ombudsman staff asked Ministry officials to review the file, and when they did, they discovered that in fact, other patients had been approved for the same treatment in the U.S. By then, however, the man's condition had advanced so that he was no longer considered eligible for the treatment. Instead, his oncologist recommended him for a different specialized treatment at the same hospital, which the Ministry approved in September 2012. After two treatments, the man reported that his condition had greatly improved and his tumours were shrinking.

Ministry officials acknowledged the need for a better system of tracking treatments approved under the Out-of-Country program. They also noted that the Ministry will rely on the expertise of Cancer Care Ontario when dealing with requests for funding out-of-country cancer treatments.

Vision of the future

The Ombudsman received four complaints in 2011 about the lack of funding for a relatively new eye surgery known as "CXL" – Corneal Collagen Cross Linking – which involves a riboflavin solution treatment for keratoconus, a condition that causes thinning of the cornea and vision loss.

All four complainants had been recommended for the treatment by medical professionals, but it was not covered by OHIP. They had all been told that their condition was worsening and they would eventually need a corneal transplant – once they reached the point of vision loss. By contrast, their specialist recommended CXL treatment as a way to improve their vision and stop progression of the disease – but it would cost up to $4,000.

Officials at the Ministry of Health and Long-Term Care told Ombudsman staff that they were discussing CXL treatment with the Ontario Medical Association and had received numerous inquiries from the public. The Ministry conducted an evidence-based review of the procedure to determine whether it should be covered by OHIP.

In early 2013, the Ministry launched a three-year pilot project to provide funding for CXL treatment through the Kensington Eye Institute. The Ministry will review the success of the procedure to determine whether or not patients subsequently still require corneal transplants. Once the data from the pilot project is reviewed, the Ministry will then determine whether CXL should be permanently added to the schedule of OHIP benefits.

MINISTRY OF LABOUR

Workplace Safety and Insurance Board

Nearly derailed

A Kingston man who had to undergo a medical assessment to maintain his Workplace Safety and Insurance Board (WSIB) benefits contacted the Ombudsman because he could not afford to pay his way to Toronto for the appointment. He had been told that the Board would pay his travel expenses, but he had called them repeatedly for a week and had received no response. He was afraid that his benefits would be cut off if he did not have the assessment.

When Ombudsman staff contacted the WSIB, they discovered the man's case manager had been changed without his knowledge. The WSIB arranged to pay for his train and taxi fare and overnight hotel in Toronto, and he was able to maintain his benefits.

Case Summaries

MINISTRY OF NATURAL RESOURCES

Fishing for proof

A Métis woman who holds a commercial fishing licence complained to the Ombudsman that she had been fighting with the Ministry of Natural Resources for six years to have her annual fishing royalty fees of $4,000 waived. She said the Ministry had asked her to provide proof that she was a member of an historic Métis community, describe her connection to the modern-day community and provide evidence of an historic and contemporary fishing right practiced in her area.

The woman had documentation from the Métis Nation of Ontario that she was a member based on their research, and felt strongly that it was not appropriate for a provincial public servant to determine whether or not she was Métis. She also argued that the information the Ministry was asking her to provide was unattainable, and that in any event, the Supreme Court of Canada had held in 2006 that Métis persons were exempt from the payment of fishing royalties.

Ombudsman staff contacted a Ministry manager who acknowledged that it might not be possible for the woman to obtain the information that the Ministry had requested. After a number of discussions, it was agreed that a genealogist would review the Métis Nation of Ontario's documentation on the woman's background.

In September 2012, the genealogist confirmed the documentation established that the woman was of Métis ancestry. Based on this information, the Ministry reimbursed her for fishing royalties paid from 2010-12, totalling about **$10,000**.

MINISTRY OF TRAINING, COLLEGES AND UNIVERSITIES

Ontario Student Assistance Program

Relief granted

A university student with a disability complained to the Ombudsman after receiving conflicting information about whether or not he was eligible for grants through the Ministry of Training, Colleges and Universities. The Student Financial Assistance Branch first told him he had not provided adequate documentation relating to his disability. Then, when he contacted them again, he was told that they had his documents but he would have to file an appeal, which he did. After 17 months, he had received no response.

Ombudsman staff contacted officials at the branch, who discovered a number of mistakes had been made, and the student had been entitled to federal grants for 2007-2010. Working with their federal counterparts, they helped the student receive $6,000 in disability grants, which were put towards repaying his student loans.

Stress therapy

A university student with a disability complained to the Ombudsman that he was being pursued by a collection agency to repay part of a grant he received through the Ontario Student Assistance Program (OSAP). An Ombudsman staff member contacted OSAP's head office, which reviewed the student's file. The student had received a total grant of $1,500 for treatment for his disability, and $711 of his expenses had been approved. The remaining $789 had been spent on a therapy that was not pre-approved by OSAP, so it was insisting the student repay that amount, although he had submitted receipts for the therapy.

Further inquiries revealed that the student had been told by a counsellor at his university that he could use his grant money for this treatment. Given that he had been given inaccurate information, OSAP agreed to cancel the debt and called off the collection agency.

MINISTRY OF TRANSPORTATION

Double trouble

A man complained to the Ombudsman that his auto insurance was about to be suspended because two convictions for speeding had been mistakenly entered on his driving record – for only one offence. He had contacted the provincial court where he was convicted and officials there confirmed there should be only one conviction, but he had been unable to get the second entry deleted through the Ministry of Transportation. He was very concerned because his job required him to drive and without valid insurance, he would be unable to work.

Ombudsman staff contacted the Ministry of Transportation, which immediately confirmed the man was correct. The duplicate entry was deleted from his record and his insurance was reinstated.

End of the line

A man complained to the Ombudsman about a frustrating delay in getting his driver's licence reinstated. It had been suspended after he suffered a seizure while driving, which was duly reported to the Ministry of Transportation. The man's doctor had put him on morphine as a painkiller for a work-related back injury, but he had stopped taking it without consulting the doctor. The doctor determined that stopping the medication was the sole reason for the seizure, and he wrote to the Ministry to explain the circumstances and recommend that the man's licence be restored.

The man was told a decision would take 30 days. When he received no word, his doctor called the Ministry and was told he would have his licence back in a few more days. Again this did not happen. The next time the doctor called the Ministry, he was told there was a missing form that had to be completed before the licence could be reinstated. The form was sent, but the man still did not get his licence. After another 10 weeks of waiting – during which the self-employed man was unable to drive himself to business meetings – he complained to the Ombudsman.

Ombudsman staff contacted Ministry officials, who arranged to have the man pick up a new temporary licence at his local ServiceOntario outlet the next day. Ministry staff apologized for the delay and revealed that the man's file had been mistakenly sent to the "back of the queue" after the form from his doctor was received.

Your Feedback

> My colleagues and I value the work of the Ontario Ombudsman in fostering a more open, accountable and responsive government. I commend the vital role you play in making sure that the provincial government acts in the best interests of Ontarians and serves them optimally.
>
> **Letter from then Premier Dalton McGuinty, July 2012**

> There is one name and one number that everyone trusts and that everyone can find. The one title that people identify with fairness, with objectivity, with impartiality … regardless of where you're from, regardless of what your faith is, what your race is, how old you are… and that is the Office of the Ombudsman.
>
> **John Vanthof, NDP MPP (Timiskaming Cochrane)**
> ***Hansard*, March 28, 2013**

> In your seven years as Ombudsman, you have launched systemic investigations into complex issues, ensured accountability among provincial agencies and positively influenced government policy. I offer my sincere congratulations.
>
> **Letter from Allan Rock, President and Vice-Chancellor, University of Ottawa, April 2012**

> On behalf of our members, I congratulate you on the well-deserved recognitions and would like to express my gratitude for your commitment in the field of ombudsmanship, and especially your contribution to the [International Ombudsman Institute] by providing it with the valuable 'Sharpening Your Teeth' training.
>
> **Letter from Peter Kostelka, International Ombudsman Institute Secretary General, October 2012**

> The expertise of the Ombudsman of Ontario [regarding police oversight] has been very valuable to our Office. Our exchanges at various levels over several years on this subject have demonstrated the importance of co-operation between parliamentary ombudsmen.
>
> **Letter from Raymonde Saint-Germain, Quebec Ombudsman, March 2013**

Comments from Facebook and Twitter

> André Marin and the Office of the Ombudsman do great work in making Ontario a better place for all Ontarians!
>
> **Gina Konjarski, via Facebook**

> I think it's a great idea that you're not only on Twitter, but ACTIVELY on Twitter. Good call!
>
> **@AshleyDevine1, via Twitter**

> I am glad that you are fighting for the people, ensuring govt checks/balances, and "humanizing" bureaucratic policies
>
> **@AndrewGOBrien, via Twitter**

> I salute you sir! You are one of the few public officials we can TRUST!
>
> **@Hohummm, via Twitter**

> Ontario is fortunate to have an Ombudsman like Mr. Marin. His passion for fairness and accountability, compounded by his no-nonsense approach, makes him a leader in the international Ombudsman world.
>
> **Danielle Cardinal, via Facebook**

> Used @Ont_Ombudsman's Twitter account in a presentation today. He's doing it right. #socialmedia
>
> **@frankchartrand, via Twitter**

Your Feedback

General comments from complainants

"Thank you so much for your time and help. I really appreciated it."

Complainant

"After many years of trying, you have helped me resolve this issue once and for all. I have received my money and my file has been closed. I really appreciate the help."

Complainant

"Thank you for the great help you gave me. You really did some wonderful work and you surely saved me a lot of trouble and I'm very thankful."

Complainant

"Your patience and thoughtfulness was evident form the first telephone contact... I am grateful for all of the time and effort you dedicated to my complaint. I am so pleased to know there are people like you who go beyond the call of duty. I will forever remember your kindness."

Complainant

"Just want to thank you folks for what you do. Very important work!"

Complainant

"I have been with the FRO for many years, trying to get my child support from my ex-husband. It's been a frustrating road, to say the least... I just wanted to let you know how thorough and committed I feel [your staff member] has been to my case. It's truly comforting."

Complainant

"Thank you for all that you do for the people and province of Ontario. Yours is a thankless job, but a most important one. So thank you for making Ontario a better place to live."

Complainant

"I am very thankful for your and your office's immensely valuable support in resolving my case in a timely way, and saving me an enormous amount of time and possibly money."

Complainant

"Thank you for the excellent work being done by your Office... It has been incredibly refreshing, as an exhausted parent dealing with the maze of government bureaucracy, to have the support of [your staff]. They clearly understand the immediate issues and find ways to identify important related systemic issues."

Complainant

Your Feedback

Comments on In the Line of Duty (October 2012)

"I have been going through hell since I was diagnosed with the illness PTSD… I am happy to see that you are seeing that the OPP needs to be held responsible."

OPP officer

"Your [operational stress injury] report has done wonders for the policing community – I cannot thank you enough. Finally police services are getting their acts together to assist members dealing with OSI. After your report came out I sent it to my Chief… He immediately scheduled a meeting upon his return and long story short I have been seconded to his office to answer to all 34 recommendations on behalf of our service."

Municipal police constable

"I am seeing changes within the organization at a speed that I have not seen in 27 years. We have a long way to go, but your office has impacted greatly on the OPP and has caused organizational reflection and hopeful efforts to address and improve our wellness. You are the catalyst to positive change in the future of policing and I am truly appreciative to your office for those who will follow in my footsteps and not have to go through what I have endured for many years."

OPP officer

"I would like to congratulate everyone involved on what appears to have been an extremely exhaustive investigation into a highly sensitive matter. It is clear that no rock was left unturned. You should all be commended for meeting this issue head-on."

OPP officer

"I and many other officers with PTSD or other stress-related injuries appreciate your attention to these complaints… The officers and families that you spoke with for your report represent only a fraction of officers who are out there and are dealing with this issue, either because of the 'wall of silence' or the fact that they haven't yet been diagnosed… Thank you for tackling this issue head-on and bringing it into the public eye and out of the shadows."

OPP staff sergeant

"I would like to commend you for your actions in relation to the suffering of police officers, particularly in the OPP…. I would like to thank you and your staff for addressing the pain and suffering of those who are expected not to feel such pain or respond to their suffering. You are all part of the accountability that is so seriously lacking."

Retired OPP officer

"You guys were all there for us, and as we move forward we know that you will continue to monitor [response to] this report. Personal stories from the heart are hard to relay, but you and your colleagues were superb. Thanks again from myself and the rest of the Toronto officers, both living and dead."

Toronto Police officer

"I am happy to see that Mr. Marin has brought light to a taboo topic within policing – the fact that we, and our families, suffer from these experiences. Please do not let the police management dissuade you; you have the thanks of the frontline police officers."

Municipal police officer

"Absolutely thrilled to see the recommendations … I know a lot of my colleagues as well who work with police and PTSD are really grateful for everything you've done."

Ontario psychologist

"I salute your clear and emphatic approach to this serious problem. I don't think the problems can be overstated and you made me cheer with the sense that our Ombudsman really stands up for Ontarians… This gives me hope that the system in Ontario is working."

Email to Ombudsman

Your Feedback

In the Media

"To heartless bureaucrats and bumbling politicians, André Marin is the proverbial skunk at a garden party. To the little guy fighting Queen's Park, he's a breath of fresh air. Since taking over as provincial Ombudsman in 2005, he's transformed the job from a quiet backwater that rarely raised a ripple to a crusading, high profile scourge of lazy, incompetent or uncaring government officials."

Christina Blizzard, *Toronto Sun*, June 20, 2012

"Does Ontario's Ornge air ambulance service require a new and tough degree of independent oversight? Only about as much as Premier Kathleen Wynne requires the support of one of the opposition parties to stay in power, which is to say: Yes, very much… Why build a new and untested infrastructure when the ombudsman's office already exists, has the necessary resources and has the track record to prove it can work? Give the oversight job to Marin. It makes sense."

Howard Elliott, *Hamilton Spectator*, March 5, 2013

"Ontario is lucky to have Ombudsman André Marin, who keeps the powerful honest. It's a good thing for some that he doesn't have the authority to lay criminal charges."

Joe Warmington, *Toronto Sun*, December 29, 2012

"Hopefully the ombudsman will help curb these excesses and usher in a new era of responsibility and accountability in the way children's aid societies fulfil their mandate."

Michael P. Clarke, *Hamilton Spectator*, October 13, 2012

"Premier Dalton McGuinty needs to level the playing field to ensure taxpayers have complete access to the services of the Ombudsman. Until the premier acts, taxpayers will be left to drown in the seas of bureaucracy."

Doug Glynn, *Midland Free Press*, August 9, 2012

"Ontario is the only province to restrict complaints by its citizens against municipalities, universities, schools, hospitals and nursing homes. What are they afraid of? If every other province can be open about their problems, why can't we?"

Kenneth Wood, letter to *Brantford Expositor*, February 5, 2013

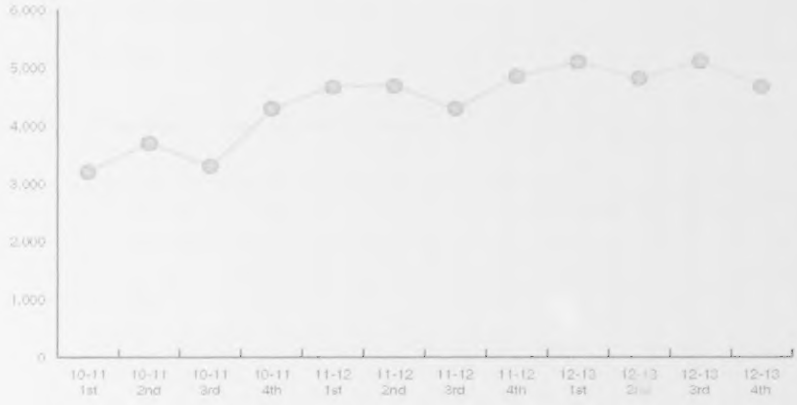
"Expanding the ombudsman's power isn't a matter of tossing a bureaucrat a bone; it's a matter of giving taxpayers government accountability they can sink their teeth into, something that'll surely be needed if they're asked to swallow more corporate approaches to whipping Ontario's books into shape."

Greg Van Moorsel, *Kingston Whig-Standard*, June 22, 2012

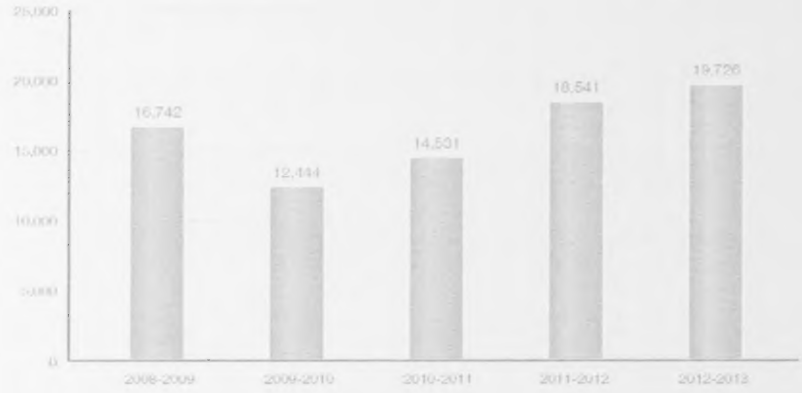
Appendix 1

Complaint Statistics

CASES RECEIVED BY QUARTER
2010-2011 TO 2012-2013



TOTAL CASES RECEIVED
FISCAL YEARS 2008-2009 TO 2012-2013

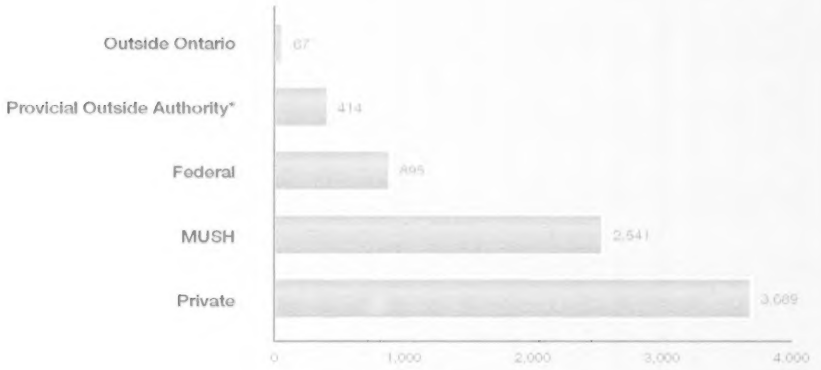


Appendix 1

Complaint Statistics

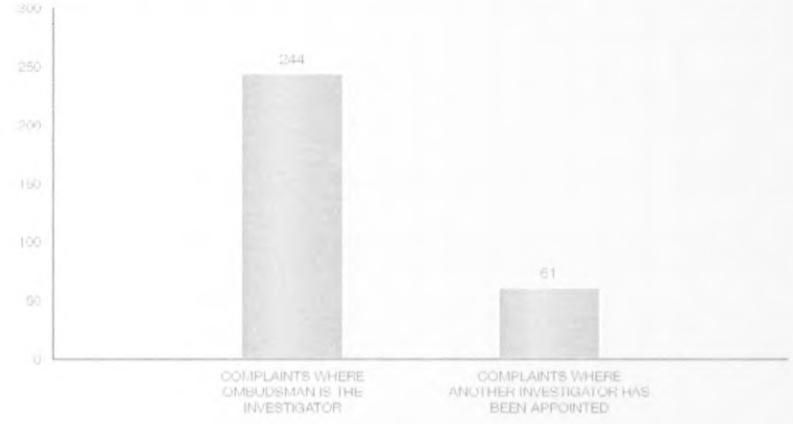
CASES OUTSIDE THE OMBUDSMAN'S AUTHORITY RECEIVED 2012-2013

TOTAL: 7,606



* For example, cases received about courts, Stewardship Ontario and Tarion

CASES RECEIVED ABOUT CLOSED MUNICIPAL MEETINGS 2012-2013*



* Note: Details of these cases will be released in a separate Annual Report later this year.

Appendix 1

Complaint Statistics

HOW CASES WERE RECEIVED 2012-2013

REGIONAL DISTRIBUTION OF COMPLAINANTS* 2012-2013

* *Excluding inmates of correctional facilities*

Greater Toronto Area: Bounded by Oakville, Lake Simcoe and Oshawa, but excluding the City of Toronto
City of Toronto: Bounded by Etobicoke, Steeles Avenue and Scarborough
Northeast: Bounded by Ottawa, Penetanguishene and Marathon north to Hudson's Bay
Northwest: West of the Marathon/Hudson's Bay boundary
Southeast: Bounded by the GTA, Penetanguishene and Ottawa
Southwest: Bounded by the GTA, Barrie and Penetanguishene

Appendix 1
Complaint Statistics

DISPOSITION OF CASES
2012-2013

Appendix 1

Complaint Statistics

TOP 15 PROVINCIAL GOVERNMENT ORGANIZATIONS AND PROGRAMS COMPLAINED ABOUT IN 2012-2013			
		NUMBER OF CASES	PERCENTAGE OF ALL CASES WITHIN AUTHORITY
1	FAMILY RESPONSIBILITY OFFICE	794	6.72%
2	DEVELOPMENTAL SERVICES PROGRAMS	631	5.34%
3	WORKPLACE SAFETY AND INSURANCE BOARD	609	5.15%
4	ONTARIO DISABILITY SUPPORT PROGRAM	565	4.78%
5	ONTARIO LOTTERY AND GAMING CORPORATION	441	3.73%
6	DRIVER LICENSING	380	3.22%
7	HYDRO ONE	328	2.78%
8	LEGAL AID ONTARIO	201	1.70%
9	ONTARIO STUDENT ASSISTANCE PROGRAM	166	1.40%
10	OFFICE OF THE PUBLIC GUARDIAN AND TRUSTEE	162	1.37%
11	LANDLORD AND TENANT BOARD	139	1.18%
12	MUNICIPAL PROPERTY ASSESSMENT CORPORATION	108	0.91%
13	ONTARIO PROVINCIAL POLICE	102	0.86%
14	WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL	101	0.85%
15	COLLEGES OF APPLIED ARTS AND TECHNOLOGY	101	0.85%

TOP 10 CORRECTIONAL FACILITIES COMPLAINED ABOUT IN 2012-2013			
		NUMBER OF CASES	PERCENTAGE OF ALL CASES WITHIN AUTHORITY
1	CENTRAL NORTH CORRECTIONAL CENTRE	665	5.63%
2	CENTRAL EAST CORRECTIONAL CENTRE	582	4.93%
3	OTTAWA-CARLETON DETENTION CENTRE	398	3.37%
4	TORONTO WEST DETENTION CENTRE	341	2.89%
5	MAPLEHURST CORRECTIONAL COMPLEX	328	2.78%
6	HAMILTON-WENTWORTH DETENTION CENTRE	278	2.35%
7	ELGIN-MIDDLESEX DETENTION CENTRE	249	2.11%
8	VANIER CENTRE FOR WOMEN	249	2.11%
9	NIAGARA DETENTION CENTRE	191	1.62%
10	TORONTO JAIL	184	1.56%

MOST COMMON TYPES OF CASES RECEIVED DURING 2012-2013	
1	DECISION WRONG, UNREASONABLE OR UNFAIR
2	ACCESS TO, OR DENIAL OF SERVICES; INADEQUATE OR POOR SERVICE
3	FAILURE TO ADHERE TO POLICIES, PROCEDURES OR GUIDELINES OR TO APPLY THEM CONSISTENTLY; UNFAIR POLICY/PROCEDURE
4	DELAY
5	ENFORCEMENT UNFAIR OR FAILURE TO ENFORCE
6	COMMUNICATION INADEQUATE, IMPROPER OR NO COMMUNICATION
7	INTERNAL COMPLAINT PROCESS; LACK OF A PROCESS, UNFAIR HANDLING OF COMPLAINT
8	BROADER PUBLIC POLICY ISSUE
9	LEGISLATION AND/OR REGULATIONS
10	GOVERNMENT FUNDING ISSUE

Appendix 1

Complaint Statistics

CASES EXCLUDING CORRECTIONAL FACILITIES RECEIVED 2012-2013 BY PROVINCIAL RIDING*	
Ajax-Pickering	66
Algoma-Manitoulin	122
Ancaster-Dundas-Flamborough-Westdale	73
Barrie	107
Beaches-East York	85
Bramalea-Gore-Malton	72
Brampton-Springdale	58
Brampton West	97
Brant	101
Bruce-Grey-Owen Sound	111
Burlington	95
Cambridge	89
Carleton-Mississippi Mills	42
Chatham-Kent-Essex	66
Davenport	44
Don Valley East	67
Don Valley West	59
Dufferin-Caledon	64
Durham	85
Eglinton-Lawrence	71
Elgin-Middlesex-London	110
Essex	87
Etobicoke Centre	49
Etobicoke-Lakeshore	78
Etobicoke North	86
Glengarry-Prescott-Russell	50
Guelph	77
Haldimand-Norfolk	93
Haliburton-Kawartha Lakes-Brock	84
Halton	99
Hamilton Centre	147
Hamilton East-Stoney Creek	103
Hamilton Mountain	68
Huron-Bruce	73
Kenora-Rainy River	68
Kingston and the Islands	101
Kitchener Centre	59
Kitchener-Conestoga	61
Kitchener-Waterloo	49
Lambton-Kent-Middlesex	60
Lanark-Frontenac-Lennox and Addington	96
Leeds-Grenville	85
London-Fanshawe	97
London North Centre	143
London West	137
Markham-Unionville	35
Mississauga-Brampton South	45
Mississauga East-Cooksville	53
Mississauga-Erindale	53
Mississauga South	66
Mississauga-Streetsville	58
Nepean-Carleton	70
Newmarket-Aurora	61
Niagara Falls	147
Niagara West-Glanbrook	73
Nickel Belt	78
Nipissing	84
Northumberland-Quinte West	77
Oak Ridges-Markham	60
Oakville	45
Oshawa	115
Ottawa Centre	56
Ottawa-Orleans	38
Ottawa South	40
Ottawa-Vanier	66
Ottawa West-Nepean	55
Oxford	67
Parkdale-High Park	75
Parry Sound-Muskoka	91
Perth-Wellington	65
Peterborough	56
Pickering-Scarborough East	48
Prince Edward-Hastings	85
Renfrew-Nipissing-Pembroke	66
Richmond Hill	71
Sarnia-Lambton	85
Sault Ste. Marie	104
Scarborough-Agincourt	32
Scarborough Centre	63
Scarborough-Guildwood	80
Scarborough-Rouge River	41
Scarborough Southwest	98
Simcoe-Grey	69
Simcoe North	119
St. Catharines	107
St. Paul's	72
Stormont-Dundas-South Glengarry	45
Sudbury	139
Thornhill	57
Thunder Bay-Atikokan	71
Thunder Bay-Superior North	73
Timiskaming-Cochrane	107
Timmins-James Bay	54
Toronto Centre	122
Toronto-Danforth	72
Trinity-Spadina	97
Vaughan	48
Welland	96
Wellington-Halton Hills	62
Whitby-Oshawa	78
Willowdale	58
Windsor-Tecumseh	87
Windsor West	104
York Centre	73
York-Simcoe	18
York South-Weston	51
York West	67

* Where a valid postal code is available.

Note: Breakdown of complaint statistics by riding is available at www.ombudsman.on.ca.

Appendix 1

Complaint Statistics

TOTAL CASES RECEIVED 2012-2013 FOR PROVINCIAL GOVERNMENT MINISTRIES AND SELECTED PROGRAMS*		
MINISTRY OF ABORIGINAL AFFAIRS		1
MINISTRY OF AGRICULTURE AND FOOD		11
AGRICORP	5	
MINISTRY OF THE ATTORNEY GENERAL		684
ALCOHOL AND GAMING COMMISSION OF ONTARIO	9	
ASSESSMENT REVIEW BOARD	6	
CHILD AND FAMILY SERVICES REVIEW BOARD	4	
CHILDREN'S LAWYER	44	
CRIMINAL INJURIES COMPENSATION BOARD	36	
HUMAN RIGHTS LEGAL SUPPORT CENTRE	12	
HUMAN RIGHTS TRIBUNAL OF ONTARIO	73	
LANDLORD AND TENANT BOARD	139	
LEGAL AID ONTARIO	201	
OFFICE OF THE INDEPENDENT POLICE REVIEW DIRECTOR	45	
OFFICE OF THE PUBLIC GUARDIAN AND TRUSTEE	162	
ONTARIO HUMAN RIGHTS COMMISSION	9	
ONTARIO MUNICIPAL BOARD	24	
SOCIAL BENEFITS TRIBUNAL	30	
SPECIAL INVESTIGATIONS UNIT	4	
MINISTRY OF CHILDREN AND YOUTH SERVICES		138
SPECIAL NEEDS PROGRAMS - CHILDREN	91	
YOUTH CUSTODY FACILITIES	34	
MINISTRY OF CITIZENSHIP AND IMMIGRATION		2
MINISTRY OF COMMUNITY AND SOCIAL SERVICES		2022
DEVELOPMENTAL SERVICES PROGRAMS	631	
FAMILY RESPONSIBILITY OFFICE	794	
ONTARIO DISABILITY SUPPORT PROGRAM	565	
ONTARIO DISABILITY SUPPORT PROGRAM – DISABILITY ADJUDICATION UNIT	19	
MINISTRY OF COMMUNITY SAFETY AND CORRECTIONAL SERVICES		4758
CORRECTIONAL FACILITIES	4477	
DEATH INVESTIGATION OVERSIGHT COUNCIL	2	
EMERGENCY MANAGEMENT ONTARIO	1	
OFFICE OF THE CHIEF CORONER	21	
OFFICE OF THE ONTARIO FIRE MARSHAL	4	
ONTARIO CIVILIAN POLICE COMMISSION	3	
ONTARIO PAROLE BOARD	8	
ONTARIO PROVINCIAL POLICE	102	
OPP-CHIEF FIREARMS OFFICER	52	
PRIVATE SECURITY AND INVESTIGATIVE SERVICES BRANCH	16	
PROBATION AND PAROLE OFFICES	52	
MINISTRY OF CONSUMER SERVICES		39
MINISTRY OF EDUCATION		41
WINDSOR-ESSEX CATHOLIC DISTRICT SCHOOL BOARD	8	
MINISTRY OF ENERGY		377
HYDRO ONE	328	
ONTARIO ENERGY BOARD	9	
ONTARIO POWER AUTHORITY	30	
ONTARIO POWER GENERATION	2	
MINISTRY OF THE ENVIRONMENT		154
DRIVE CLEAN PROGRAM	10	
MINISTRY OF FINANCE		692
FINANCIAL SERVICES COMMISSION	46	
LIQUOR CONTROL BOARD OF ONTARIO	17	
MUNICIPAL PROPERTY ASSESSMENT CORPORATION	108	
ONTARIO LOTTERY AND GAMING CORPORATION	441	
ONTARIO RACING COMMISSION	4	
ONTARIO SECURITIES COMMISSION	9	

Total figures are reported for each provincial government ministry, including all agencies and programs falling within its portfolio.

Appendix 1

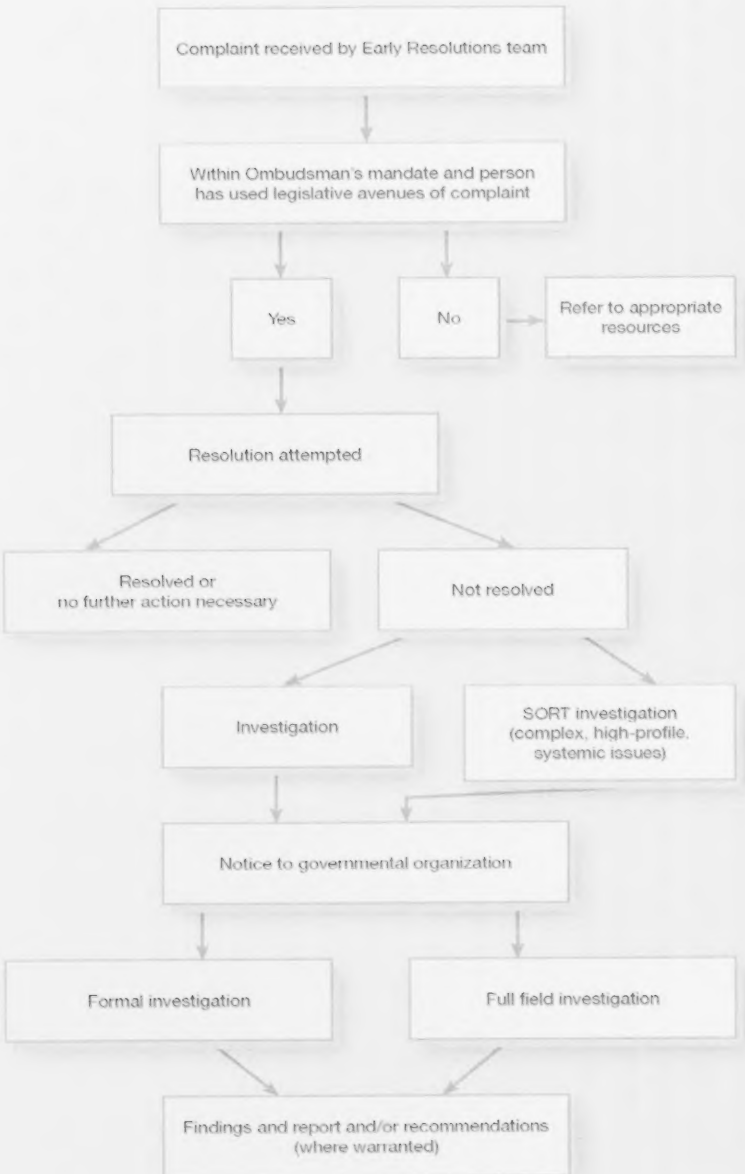
Complaint Statistics

TOTAL CASES RECEIVED 2012-2013 FOR PROVINCIAL GOVERNMENT MINISTRIES AND SELECTED PROGRAMS*		
MINISTRY OF GOVERNMENT SERVICES		210
LICENCE APPEAL TRIBUNAL	10	
ONTARIO PENSION BOARD	4	
REGISTRAR GENERAL	80	
SERVICEONTARIO	76	
WORKPLACE DISCRIMINATION AND HARASSMENT PREVENTION	4	
MINISTRY OF HEALTH AND LONG-TERM CARE		523
ASSISTIVE DEVICES / HOME OXYGEN PROGRAMS	16	
CANCER CARE ONTARIO	4	
COLLEGE OF DENTURISTS OF ONTARIO	4	
COMMUNITY CARE ACCESS CENTRES	94	
CONSENT AND CAPACITY BOARD	6	
HEALTH PROFESSIONS APPEAL AND REVIEW BOARD	26	
HEALTH SERVICES APPEAL AND REVIEW BOARD	15	
HÔTEL-DIEU GRACE HOSPITAL	2	
LOCAL HEALTH INTEGRATION NETWORKS	16	
NIAGARA HEALTH SYSTEM	31	
NORTHERN HEALTH TRAVEL GRANT	13	
ONTARIO HEALTH INSURANCE PLAN	98	
ONTARIO PUBLIC DRUG PROGRAMS	91	
PERFORMANCE IMPROVEMENT AND COMPLIANCE BRANCH	38	
PSYCHIATRIC PATIENT ADVOCATE OFFICE	3	
MINISTRY OF INFRASTRUCTURE		1
INFRASTRUCTURE ONTARIO	1	
MINISTRY OF LABOUR		814
EMPLOYMENT PRACTICES BRANCH	29	
FAIR PRACTICES COMMISSION	2	
GRIEVANCE SETTLEMENT BOARD	3	
OCCUPATIONAL HEALTH AND SAFETY BRANCH	12	
OFFICE OF THE EMPLOYER ADVISER	1	
OFFICE OF THE WORKER ADVISER	18	
ONTARIO LABOUR RELATIONS BOARD	34	
PAY EQUITY COMMISSION	2	
PUBLIC SERVICE GRIEVANCE BOARD	1	
WORKPLACE SAFETY AND INSURANCE APPEALS TRIBUNAL	101	
WORKPLACE SAFETY AND INSURANCE BOARD	609	
MINISTRY OF MUNICIPAL AFFAIRS AND HOUSING		25
MINISTRY OF NATURAL RESOURCES		67
CROWN LAND	11	
LICENCES/TAGS	13	
NIAGARA ESCARPMENT COMMISSION	4	
MINISTRY OF NORTHERN DEVELOPMENT AND MINES		8
MINISTER RESPONSIBLE FOR FRANCOPHONE AFFAIRS		1
OFFICE OF FRANCOPHONE AFFAIRS	1	
MINISTRY OF TOURISM, CULTURE AND SPORT		10
MINISTRY OF TRAINING, COLLEGES AND UNIVERSITIES		343
APPRENTICESHIP	9	
COLLEGES OF APPLIED ARTS AND TECHNOLOGY	101	
ONTARIO COLLEGE OF TRADES	4	
ONTARIO SELF-EMPLOYMENT BENEFIT	7	
ONTARIO STUDENT ASSISTANCE PROGRAM	166	
PRIVATE CAREER COLLEGES BRANCH	19	
SECOND CAREER	22	
MINISTRY OF TRANSPORTATION		508
DRIVER LICENSING - MEDICAL REVIEW SECTION	169	
DRIVER LICENSING	211	
METROLINX/ GO TRANSIT	15	
VEHICLE LICENSING	44	

** Total figures are reported for each provincial government ministry including all agencies and programs falling within its portfolio.*

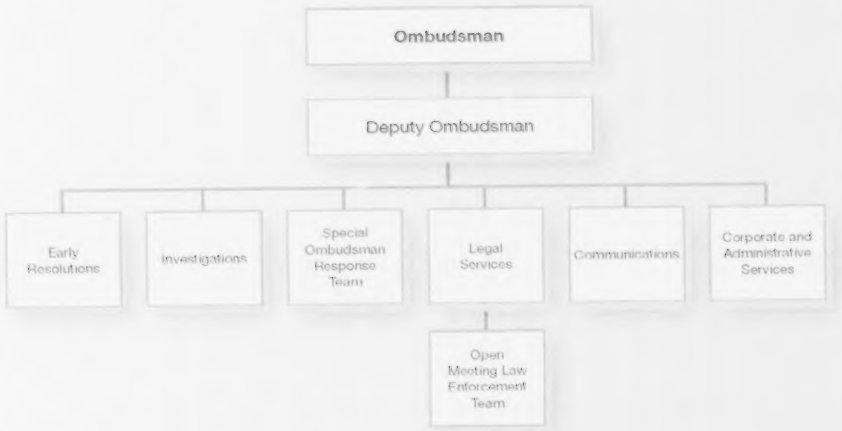
Appendix 2

How We Work


Complaint received by Early Resolutions team
Within Ombudsman's mandate and person has used legislative avenues of complaint
Yes
No
Refer to appropriate resources
Resolution attempted
Resolved or no further action necessary
Not resolved
Investigation
SORT investigation (complex, high-profile, systemic issues)
Notice to governmental organization
Formal investigation
Full field investigation
Findings and report and/or recommendations (where warranted)

Appendix 3

About the Office



Early Resolutions: The Early Resolutions team operates as the Office's front line for receiving, triaging and assessing complaints, providing advice, guidance and referrals to complainants. Early Resolution Officers use a variety of conflict resolution techniques to resolve complaints that fall within the Ombudsman's jurisdiction.

Investigations: Complaints that cannot be easily resolved are referred to Investigations. The Investigations team conducts issue-driven, focused and timely investigations of individual complaints and systemic issues.

Special Ombudsman Response Team (SORT): The Special Ombudsman Response Team conducts extensive field investigations into complex, systemic, high-profile cases. SORT investigators work in collaboration with Early Resolutions, Investigations and Legal Services, and additional staff are assigned to SORT as needed.

Legal Services: The Legal Services team ensures that the Office functions within its legislated mandate and provides expert advice to the Ombudsman and staff in support of the resolution and investigation of complaints, the review and analysis of evidence and the preparation of reports and recommendations.

Open Meeting Law Enforcement Team (OMLET): OMLET investigates complaints about closed municipal meetings (received pursuant to the *Municipal Act*) and engages in education and outreach with municipalities and the public with regard to open meetings.

Communications: In addition to co-ordinating the Ombudsman's reports, brochures, other publications and videos, the Communications team maintains the Ombudsman's website and social media presence, assists in outreach activities, and provides support to the Ombudsman and staff in media interviews, press conferences, speeches, presentations and public statements.

Corporate and Administrative Services: The Corporate and Administrative Services team supports the Office in the areas of finance, human resources, administration and information technology.

Appendix 4

Financial Report

During the fiscal year 2012-2013, the total operating expenditures for the Office were **$11.159** million. Miscellaneous revenue returned to the government amounted to **$44,000**, resulting in net expenditures of **$11.115** million. The largest categories of expenditures relate to salaries, wages and employee benefits at **$8.561** million, which accounts for 76.7% of the Office's annual operating expenditures.

SUMMARY OF EXPENDITURES 2012-2013	
	(In thousands)
Salaries and wages	$7,040
Employee benefits	$1,521
Transportation and communications	$339
Services	$1,537
Supplies and equipment	$722
Annual Operating Expenses	**$11,159**
Less: Miscellaneous revenue	$44
Net Expenditures	**$11,115**